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ABSTRACT

Proceedings are presented of the Second Annual Second-Step Nursing Education Conference. (Second-step nursing education encompasses postlicensure, upper-division baccalaureate programs expressly designed for registered nurses.) The texts of seven formal presentations at the conference are given including four in the area of national second-step project outcomes and three on professionalism. Specific presentations includes Leadership in Second-Step Programs: Problems and Solutions: Three Models of Second-Step Programs: The Ideal vs. the Real: Professionalization of Nursing Students in Second Step: and Characteristics of Novice and Expert Performance: Implications for Teaching and Experienced Nurse. The texts of three panel discussions are also provided. Panel topics included (1) the discrepancy between the position that registered nurses are already licensed as safe practitioners and the position that such licensures is insufficient evidence of their readiness to undertake an upper-division nursing program, (2) the unique processes and problems involved in developing a baccalaureate program for registered nurses, and (3) accreditation. (LRA)

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VOLUME 2.

PROCEEDINGS

RESEARCHING SECOND STEP NURSING EDUCATION

Second Annual Conference

January 12-13, 1981

San Francisco, California

Katherine L. Jako, Editor

CE 027 935

Sonoma State University
Rohnert Park, California

National Second Step Project
Department of Nursing

February 1981

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PREFACE

This volume is the second of a matching set. A researcher's regard for elegance of design, as well as an editor's antipathy for verbal redundance, prompts me to refer the reader to the 1980 edition* for the background story--that chronology of circumstances and events which led not only to the conference herein reported, but also to the development of the Second Step curricular model in nursing education and, hence, to the establishment of the National Second Step Project, scheduled for completion in June 1981. In this series of two national research conferences, our goals were to uncover significant investigations being conducted in this field, to bring those researchers together in an atmosphere conducive to dialogue, and to provide a sounding board for information rooted in systematic and scholarly inquiry--information needed both by those who carry the research forward and by those who develop and take part in the programs themselves. With no undue modesty, I believe we can lay claim to the achievement of those goals.

Looking back upon the two conferences, one can speculate as to the directions in which Second Step research is moving--its significance for nursing education as well as its potential impact upon the profession at large. One of the more promising developments is a slight but perceptible shift to a higher level of abstraction. The sense of isolation is lessened, and the connections and linkages are beginning to be made. Evidence and insights from one study can be seen to support or to weaken inferences from another. To my mind, the most fruitful outcome of any research process occurs in the form of a question; only when better questions are asked and better problems are posed will better answers and solutions be forthcoming.

At the same time, honest critique compels a contrary observation: a sort of yearning for specific and concrete facts with immediate and unambiguous applicability. Among would-be researchers, this emerges as the show-and-tell syndrome, still alive and well; among audience participants it is manifested in collective demands for clear-cut and positive

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*Available through ERIC: See April 1981 issue of Resources in Education (ED 194 790).

"findings" which will define for them a single and unquestionable course of action. And why not? Just as the clinical practitioner must deal with the immediate needs of each individual patient, Second Step nursing educators must live in the real world of specific programs experiencing very real and urgent problems.

As a result, the event which took place in January 1981 was not constructed entirely from the researcher's theoretical perspective. While it still retained a primary research orientation, it also bore some semblance of a special-interest group, with political as well as practical ramifications. That secondary identity was expressed through a series of panel discussions built around three current and controversial issues: validation of students' prior learning; program development; and NLN accreditation procedures. Although space limitations prevent the inclusion in their entirity of these verbal exchanges amongst both the experts and the audience, latter portions of this volume present the leading questions that were formulated to guide the discussions, as well as the introductory remarks of each panelist.

In a lighter vein, I might report that we took quite seriously the many comments from the 1980 conference evaluation forms that told us, in no uncertain terms, that the meeting room was too hot. Result? Our 1981 participants complained, with equal vehemence, that the rooms were too cold. What can I say? Perhaps in the thermostatically controlled climate of your own homes and offices, these Proceedings can be more comfortably digested. We commend them to your thoughtful attention, and trust that you will continue the dialogue thus begun.

Katherine L. Jako, Editor
February 13, 1981.

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A PREVIEW OF NATIONAL SECOND STEP PROJECT OUTCOMES

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Five Professional Nursing Orientations

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FIVE PROFESSIONAL NURSING ORIENTATIONS

Katherine L. Jako

As the lead-off speaker in today's National Second Step lineup, let me begin by advising you that all of us are suffering from information overload. One of the dangers of having lived with these data for the past two and a half years is that the broad outlines of our study population have become devastatingly familiar--to us--and there is a tendency to assume that the rest of the world is similarly informed. So before I launch into an explication of these "five professional nursing orientations," let me explain that they are NOT taken from a review of the nursing literature, nor are they based on prior research other than a previous study which also utilized a Second Step population (Jako et al., 1978). Rather, they represent global categories derived from data which came exclusively from Second Step nursing students. They are discernable within "our" population and, as such, they serve to help us in understanding that population. Some degree of generalizability is probably warranted, but the relative prevalence of one orientation or another, and even the characteristics associated with them, may differ from one setting to the next. So as I speak of what is noteworthy about each orientation, it will always be in terms of how it is distinguishable from this total group of registered nurses enrolled in six NSSP programs. Comparisons with other populations, such as "all RNs" or students in generic programs, must await further research.

I hope you are wondering why I called them "professional" orientations, because that's the next thing I'd like to explain. Since the late fifties, nurses have been fascinated with their own professionalism, or lack thereof (McKinney and Ingles, 1959; Corwin, 1961; Davis and Olesen, 1964; Kramer, 1970). Building on the work of Corwin, Kramer has perhaps reached the widest readership with a series of books and articles that contrast the "professional" with the "bureaucratic" role conception, glorifying the former and denigrating the latter (see, for example, Kramer, 1968, 1969, 1970, 1974). I don't have time to build my case in this short presentation; but by inserting the word "professional" into the title, my implication is that nurses need not necessarily shun all bureaucratic organizations (which, incidentally, include educational institutions as well as most health care facilities) in order to earn the somewhat symbolic and honorific title of "professional." That term of approbation, I would suggest, can be legitimately applied to a number of different nursing orientations, some more bureaucratic than others.

Next question: Why look at orientations at all? These students will all take approximately the same courses and earn the same degree anyway; our job is to educate them, not to classify them! Well, that's probably true, but I came across an interesting paragraph in a recent nursing journal that I'd like to quote. The title of the article, by the way, is "Faculty Burnout."

> The once comfortable, familiar, all-generic student population is passing into extinction. Probably, it should, because it overlooked the needs of many members of our society, but the shift exacts its toll from nursing faculty. Once accustomed to teaching a relatively homogeneous group, they now find themselves teaching RNs returning for a baccalaureate, transfers from other or previous majors, mid-life career changers, first-time adult learners, or the homemakers who, having dropped out of nursing school to get married, have now decided they want to try it again. Men students compound the mix even further, coming from such diverse backgrounds as Vietnam or religious orders. These students have every right to a nursing education; nevertheless, teaching this broad spectrum of students is demanding and exhausting. (Lenhart, 1980, p. 424)

What I would suggest is that such diversity, when understood, can strengthen rather than weaken both your nursing program and your profession.

In essence, the five orientations represent a refinement of a four-way classification derived from an earlier analysis of qualitative data collected from only one Second Step program during 1972 through 1975 (Jako et al., 1978). The question at that time was as follows: Early in the Second Step experience, and regardless of the clarity of students' perceived options, toward what kinds of nursing roles are these students predisposed and/or inclined? Using an open-coding procedure, four orientations were discerned and defined as follows:

TRADITIONAL: Interested in straight-line, traditional positions, as in a hospital or doctor's office, but not including those described as "alternative," "holistic," etc.

LEADERSHIP: Sights set on rising in job hierarchy, whether bureaucratic, hospital or other, especially if this is unspecified.

ACADEMIC: Interested in academic roles, including research.

FRONTIERING: Shows interest in positions that are non-traditional; questions established health care delivery; is innovative, flexible.

In the present study, the same qualitative data were collected. On our "Entry Questionnaire," students were asked to respond in their own words to the following items:

- When did you decide to get a baccalaureate in nursing, and what were your circumstances at that time?
- For what reason(s) did you decide to get a baccalaureate in nursing?
- For what reasons did you choose this particular nursing program?
- Do you have any special expectations of the nursing program in which you are enrolled? If so, what are they?
- Describe briefly the position you would like to have after graduation.
- What are your long-range plans for a position in nursing?

These data, however, were collected from a broad range of students, enrolled in six diverse programs rather than only one, and at a later point in time--1978 and 1979. Partially because of these factors, the number of orientations was expanded from four to five, and the definitions were both clarified and tightened. All five are still based essentially upon the kinds of role expectations voluntarily expressed by entrants, and bearing upon their own futures in nursing.

The TRADITIONAL orientation is now replaced by two separate categories. Both are built around the provision of service and care for patients or clients, and the roles are played out within relatively conventional patient-care settings which serve further to define those roles. One is the IN-PATIENT facility, whether acute or long-term. Here the nurse provides direct care and service in a stable and relatively controlled environment. The other is the out-patient facility or COMMUNITY agency organization, whether public or private. Here again, the nurse expects to provide care and service to patients or clients, but the practice setting itself is less structured. These nursing care activities may extend into the community, and the definition of "client" may extend to family, associates and others. Yet the essence of the role is still the provision of service and care, and the manner in which care is provided is still controlled and further defined by the structure of the organization which employs and directs those nursing activities.

The LEADERSHIP orientation is now renamed VERTICAL MOBILITY, avoiding some of the semantic ambiguities of the former label. Most of these roles are probably, but not necessarily, played out in one of the conventional types of settings previously described. Yet the essence of the role is defined not in terms of its caring and serving function, but in terms of power relationships among providers of care, clients and institutions broadly defined. Access to such authority may come either through promotions and seniority, or through the possession of special expertise. Its hallmark is advancement, either through the institutional or the wider professional ranks of nursing. The expected role is one of influence and authority, regardless of the sphere in which it is exerted.

The ACADEMIC orientation survives intact. It is built around the acquisition and dissemination of knowledge. Most of these nursing roles are played out on the terrain of the postsecondary educational institution, or that part of the professional nursing turf that is primarily concerned with education, research, publication and academic advancement. In this "practice setting," nursing is more of an academic discipline than an activity. The prototype may be less interested in providing patient care than in teaching, conducting research, or perhaps promoting the status and respectability of academic nursing. The basic commodity is information or knowledge. Academic skills themselves are what the nurse hopes to market, not the nursing skills which an advanced degree may have provided.

The last orientation is still called FRONTIERING. It is built around movement into new areas of nursing responsibility. Such roles are defined not by links with any particular type of practice setting, but by the manner in which the nurse expects to function. In general, the nurse expects to enjoy greater independence than is characteristic of traditional nursing roles. In some cases, these "new" roles involved relationships with patients or clients that have, in the past, been more typical of the physician's role--as in the role of the independent Nurse Practitioner. In other cases, role expectations are consciously grounded in a desire to change the profession, either by using nursing competence to promote the health of society, or by improving the present health care delivery system and the function of nursing within it. Because such roles are not yet well-established, they often require the tastes and talents of the entrepreneur.

During 1978 and 1979, approximately seven hundred entering students provided relevant qualitative data. From their answers to the questions cited earlier and with particular attention to post-graduate employment expectations, each respondent was coded as to the clarity with which each orientation was reflected, and as to which (if any) of the five was "dominant"--i.e., was judged to characterize this student's general orientation to nursing at that time.

Responses were not "forced" into the five categories. Students were free to write in whatever they wished to say, and there were many instances in which either no orientation could be clearly discerned, or in which two or more orientations were expressed with equal emphasis. These were coded "missing data." Almost two-thirds, however, were sufficiently consistent and unambiguous. Although some expressed two or more orientations, only one was judged "dominant" and that one was also clearly expressed in the writer's prose. As shown in Table 1, these 437 cases were distributed somewhat unevenly among the five orientations. The Academic and Vertical Mobility groups were smaller; the Frontiering group was larger; and both Traditional groups fell in between.

Table 1: SAMPLE DISTRIBUTION AT ENTRY

ORIENTATION CODING CATEGORIES*		NUMBER	PERCENT OF TOTAL
IN-PATIENT, Traditional	(20.6)	90	13.0%
COMMUNITY, Traditional	(22.0)	96	13.9%
VERTICAL MOBILITY	(14.9)	65	9.4%
ACADEMIC	(14.6)	64	9.2%
FRONTIERING	(27.9)	122	17.6%
Sub-Total:	(100%)	437	63.1%
NONE BOTH CLEAR AND DOMINANT		256	36.9%
Total:		693	100%

*Mean Reliability (Inter-coder Agreement) = .82

Early in the analysis, we explored scaling techniques to "measure" the five orientations from the wide range of quantitative data available at entry and again at graduation. Quantitative measurements scales never materialized, but the process (using factor analysis with two large pools of attitudinal variables, one from entrants and one from graduates) was highly instructive.

In general, the factors did tend to correspond roughly with the five conceptual categories, but much more clearly at entry than at graduation. For instance, the In-Patient orientation was fairly distinct from Vertical Mobility at entry. In the graduation data, these two orientations blend together. In other words, those graduates who retain an interest in hospital nursing also tend to indicate ambitions for moving up in the hierarchy toward supervisory positions. Or, starting from the other end, you could say that many of those whose primary orientation was toward roles of influence and authority also, as graduates, tend to indicate an interest in remaining within the hospital setting and working their way up through the ranks. On the other hand, another route to influence and authority is by way of academia--acquiring additional expertise, knowledge and credentials. Thus, a similar blend occurs in the graduation data between Academic and Vertical Mobility. Even the Frontiering factor, which at entry was defined primarily by high loadings in terms of self-employment and interest in the Nurse Practitioner specialization, is at graduation much less clearly defined. It blends both with the Community orientation in terms of non-institutional practice settings, and with the Academic orientation in terms of self-employment. In the NSSP data, then, these five nursing orientations exist as "ideal types" rather than as measurable dimensions. Factor analysis of both entry and graduation data indicates that a certain realignment of attitudes, preferences and interests seems to take place during the course of the Second Stepper's educational experience. One effect of this realignment is that role expectations become more complex and less uni-dimensional.

Another lesson from factor analysis was that in terms of attitudinal data, the two so-called "traditional" orientations have little in common. The rationale for considering a proclivity for Community Health nursing to be a "traditional" orientation was based primarily upon history. Community Health has, after all, been included in baccalaureate curricula for many years and could hardly be called wildly innovative in 1978. Yet items upholding many traditional perspectives on nursing roles and health care[1] were positively correlated only with the In-Patient orientation; correlations with the Community orientation were either negligible or negative. Such outcomes indicate that if we want to call Community Health a "traditional" nursing specialization we can, but Second Step nursing students who are interested in those positions do not necessarily give evidence of "traditional" attitudes and interests.

These and other analyses clarified the nature of the orientations and how they relate to one another in terms of a theoretical dimension of traditionalism among Second Step nursing students. Frontiering still appears the least traditional, so they occupy the low point, followed by those with a Community orientation. The In-Patient group still appears the most traditional, so they occupy the high point, with Vertical Mobility adjacent. In the middle are the Academics who appear traditional in some ways and non-traditional in others.

Table 2: TRADITIONALISM IN EXPRESSED ORIENTATION TOWARD NURSING ROLES

Orientations at Entry		Type of Second Step Program 2 + 2 (N=187) %	 Upper 2 (N=250) %	Total Population (N=437) %
Low:	1 = FRONTIERING	16.6	36.4	27.9
	2 = COMMUNITY	18.2	24.8	22.0
	3 = ACADEMIC	12.8	16.0	14.6
	4 = VERTICAL MOBILITY	19.8	11.2	14.9
High:	5 = IN-PATIENT	32.6	11.6	20.6

The new dimension is called "traditionalism in expressed orientation toward nursing roles," since each respondent was coded from voluntarily expressed qualitative data rather than from forced-choice items. As a theoretical construct, it suggests that the total population of Second Step entrants veers slightly toward a non-traditional orientation, half coded toward the low end, just over a third toward the high end, and the remainder occupying a middle ground. But a stark contrast occurs between students entering a 2 + 2 program (where the same institution grants an ADN and a BSN) and those entering an Upper 2, which grants only the baccalaureate. Although both are technically "post-licensure" programs, the implication is that they are attracting and educating vastly different student clienteles, at least in terms of this one dimension.

The validity of the construct will stand or fall on whether or not other characteristics of the five groups seem to form a coherent and interpretable portrait of each group. We begin with a series of horizontal bar graphs, the first of which (Figure 1.) shows four background and demographic variables. The question is: Do the orientation groups differ on these variables and, if so, at what level of significance? An "N.S."

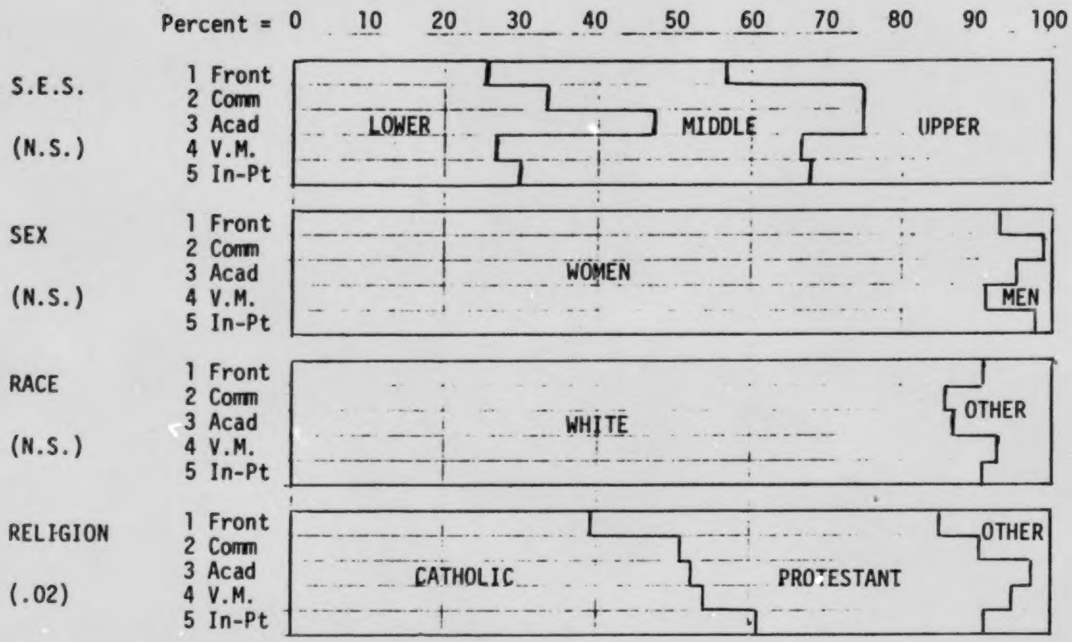

Figure 1.

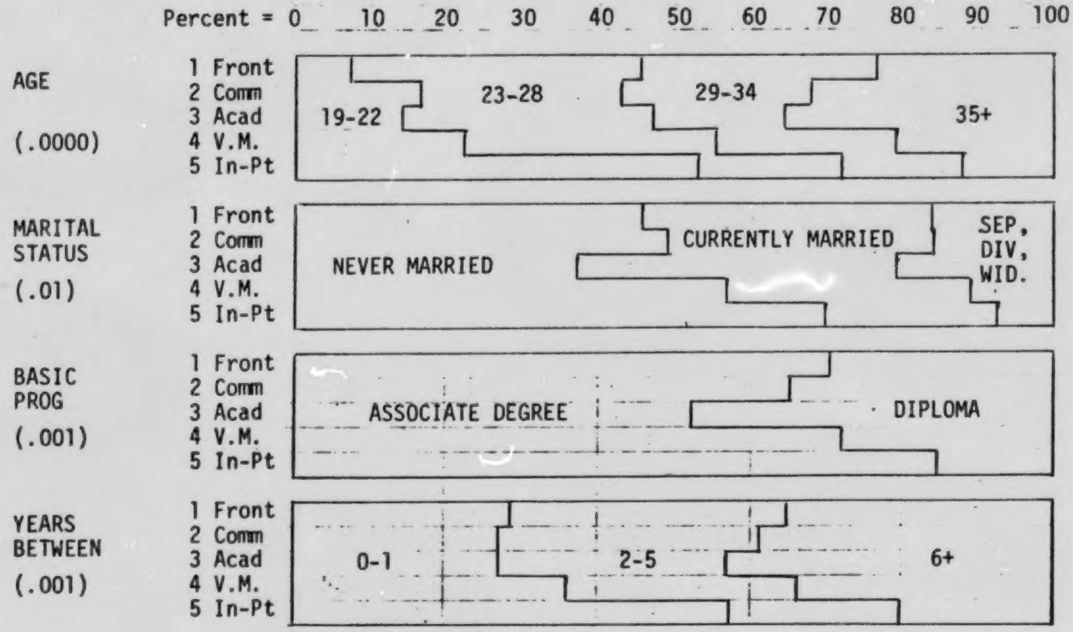

Figure 2.

(not significant) indicates that, using chi-square, differences among the five groups are not statistically significant, even though one group or another may stand out from the rest. Socioeconomic status, for instance, shows the Frontiering group to come from a little more affluence and the Academics from a little less, but overall the group differences are not significant. Sex and race differences are also negligible. Religious background, however, does differ significantly; the stair-step pattern of the Catholic responses suggests a linear relationship between Catholicism and traditionalism in nursing orientation.

Conventional wisdom derived from the social and political sciences tends to link traditionalism with age and non-traditionalism with youth. Figure 2 shows that Second Step student data not only fail to support that formulation, but they tend to confirm the opposite: a negative and linear relationship between age and the degree of traditionalism expressed (Pearson's r = -.26). More than half (53%) of the In-Patient group enrolled at the age of 22 or less, compared to just a handful (8%) of the Frontiering group. This single demographic fact has its effect upon other variables. Thus, those in the more traditional orientations are far less likely to have married, and they probably earned an ADN rather than a hospital diploma. As to the number of years between completing their basic nursing preparation and entering a Second Step program, here too we see a dramatic difference, with the time lapse being far shorter among the most traditional group. Note, however, that the Academics tend to break up the linearity of these relationships: they include the most students over the age of 34, the most who are or have been married, the most who completed a hospital program, and the most with a lapse of six or more years between basic and baccalaureate program.

Figure 3 shows only a handful of these students to have earned additional credentials or degrees prior to entry, and differences between the orientation groups are negligible. So in terms of "formal education," they are roughly equivalent. But when we look at when they made the decision to go for a baccalaureate, the In-Patient group stands out sharply; most of them decided before being RNs, which no doubt affects the next

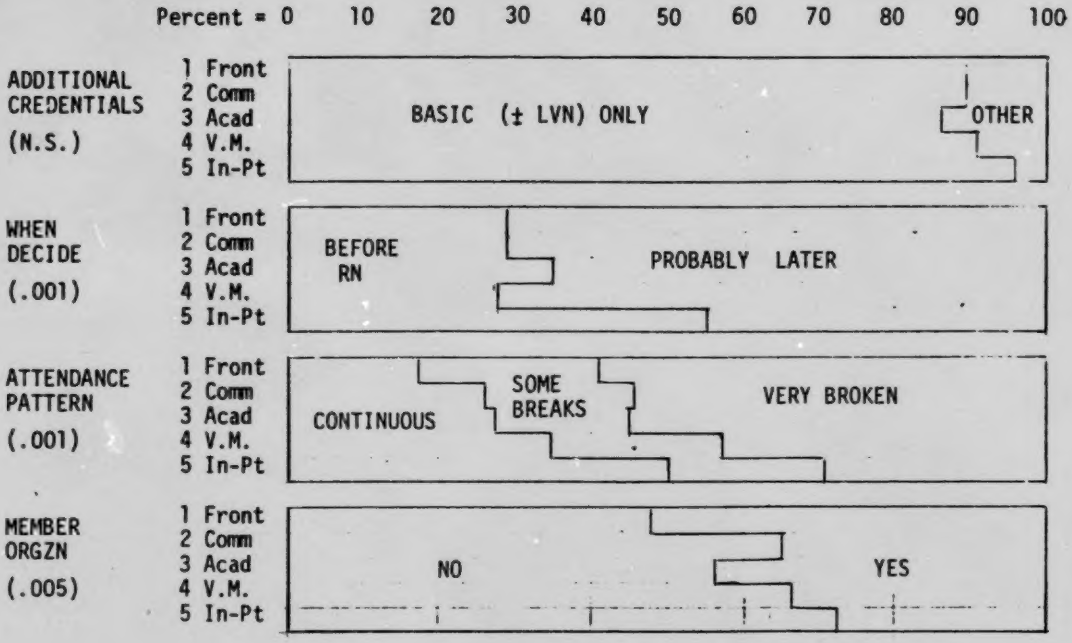

Figure 3.

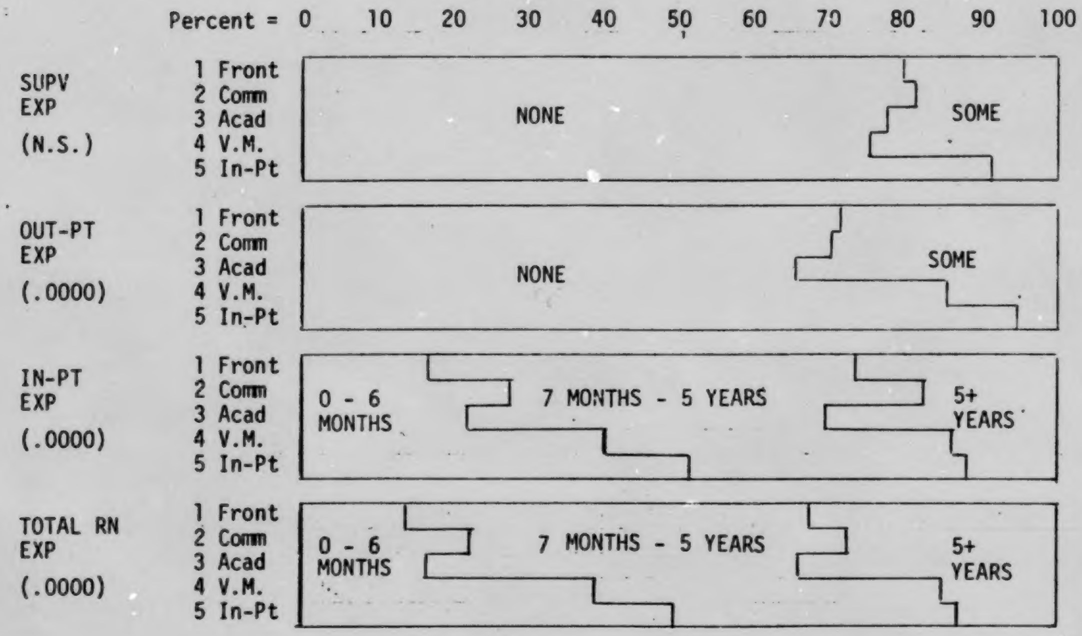

Figure 4.

variable--attendance pattern throughout their postsecondary education. Continuous enrollment is much more characteristic of the most traditional groups, but relatively rare for Frontiering.

The next variable indicates whether these students, as they entered a Second Step program, were members of professional nursing organizations. Again, the difference is significant and can be attributed in part to age differences. The traditionalists, who never intended to stop with an RN and who probably went straight from a basic to a baccalaureate program, are least likely to hold memberships--perhaps because they hadn't yet had as much time as the others to get involved. More than half of the Frontiering group, on the other hand, having spent more time out of school, had joined these organizations and were already active members as they began their baccalaureate education.

In terms of actual months of RN work experience prior to entry, Figure 4 simply confirms what all the preceding information would lead you to expect. Relatively few Second Step students, regardless of orientation, arrive with supervisory experience. Not many have experience in out-patient settings, but those that do are over-represented among the less traditional groups. Experience in the hospital setting is quite common, but again it is the traditionalists who tend to have only six months or less. Added together, you can see a clear negative relationship (Pearson's r = -.27) between RN work experience and traditionalism in nursing orientation. Among aspiring Second Step students, the traditional image of the angel of mercy, ministering efficiently but tenderly in a well-run hospital, seems to fade perceptibly as that environment becomes more familiar.

Figure 5 presents an entirely different kind of data--the mean personality profile of entering Second Step students. The basic question becomes: Do personality characteristics differ significantly by orientation group? According to scale scores from the Omnibus Personality Inventory, the answer is "Yes, in most cases." That is, an analysis of variance using the five orientation groups as sub-samples yielded significant differences on eleven of the fourteen scales--two at .04 and the rest at or below .01. These eleven include all six intellective scales, three social adjustment scales and two others.

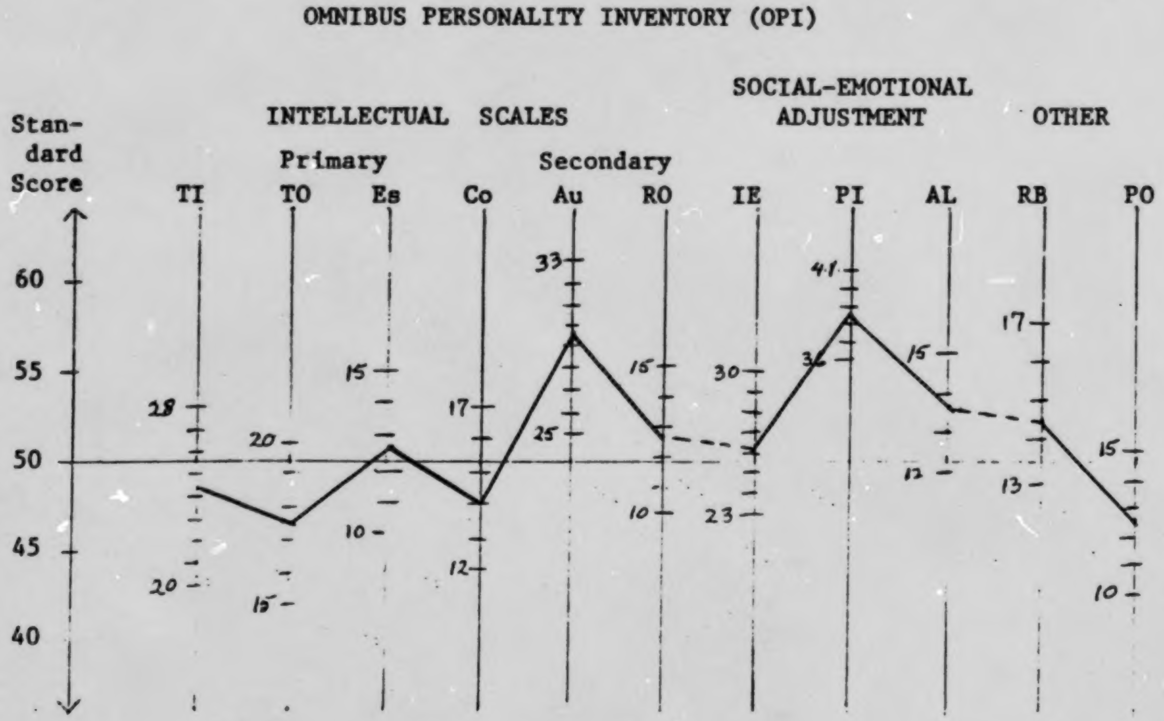

Figure 5. OPI Profile for the Total NSSP Sample at Entry (N=786)

This brief presentation cannot do justice to the whole story on the Second Step student personality, but Figure 5 shows the basic outline as derived from the total of almost 800 respondents at entry, combining all orientations. All the sub-groups will be a variation of this general "shape." Only those scale scores that differ significantly by orientation group are shown.[2]

There are two "peaks" which, for the total sample, are at roughly the same level. One is Autonomy (Au) and the other Personal Integration (PI). At entry they appear to be remarkably independent, non-authoritarian and positively socialized. The rest of the scores hover reasonably close to the standardized mean--a bit low on both Theoretical Orientation (TO) and Practical Outlook (PO), and a bit high on Anxiety Level (AL) which is scored in the reverse direction and actually measures a lack of anxiety.

Now, let's look at the orientation groups, going from the most to the least traditional. The traditional In-Patient group (Figure 6), while still showing a modified version of the two peaks that we have come to associate with Second Step students in general, is characterized mainly by low scores on the primary intellectual scales: Thinking Introversion (TI), measuring a liking for ideas and reflective thought; Theoretical Orientation (TO), measuring a taste for scientific thinking and problem-solving; Estheticism (Es) which taps artistic interests; and Complexity (Co) which measures a flexible approach and tolerance of ambiguity. Religious Orientation (RO) assesses religious liberalism, so they express more conventional religious beliefs and behaviors than do most Second Step students. Impulse Expression (IE) shows them also to be more restrained, in spite of their youth; and AL indicates that they tend to express more worries and anxiety. RB stands for Response Bias; the easiest way to explain it is to think of it as measuring how much you, as a respondent, are out to "put your best foot forward" or to "make a good impression" on the OPI. Among the In-Patient group, not very much. And the last one, Practical Outlook (PO), shows them to be about as pragmatic and utilitarian as most other college students. These may be very good nurses--well socialized and not excitable--but they will do best in relatively structured situations that don't demand a lot of abstract thinking and coping with ambiguities.

The profile for the Vertical Mobility group (Figure 7) is remarkably similar to that of the total NSSP population. Estheticism (Es) and Complexity (Co) drop a bit below the overall mean, so they too show no particular fondness for artistic concerns or for novel situations and ambiguities. They're also less religious (RO) and a little more expressive (IE), and although their score on practicality (PO) is definitely lower than the In-Patient group, they nonetheless are reasonably practical and

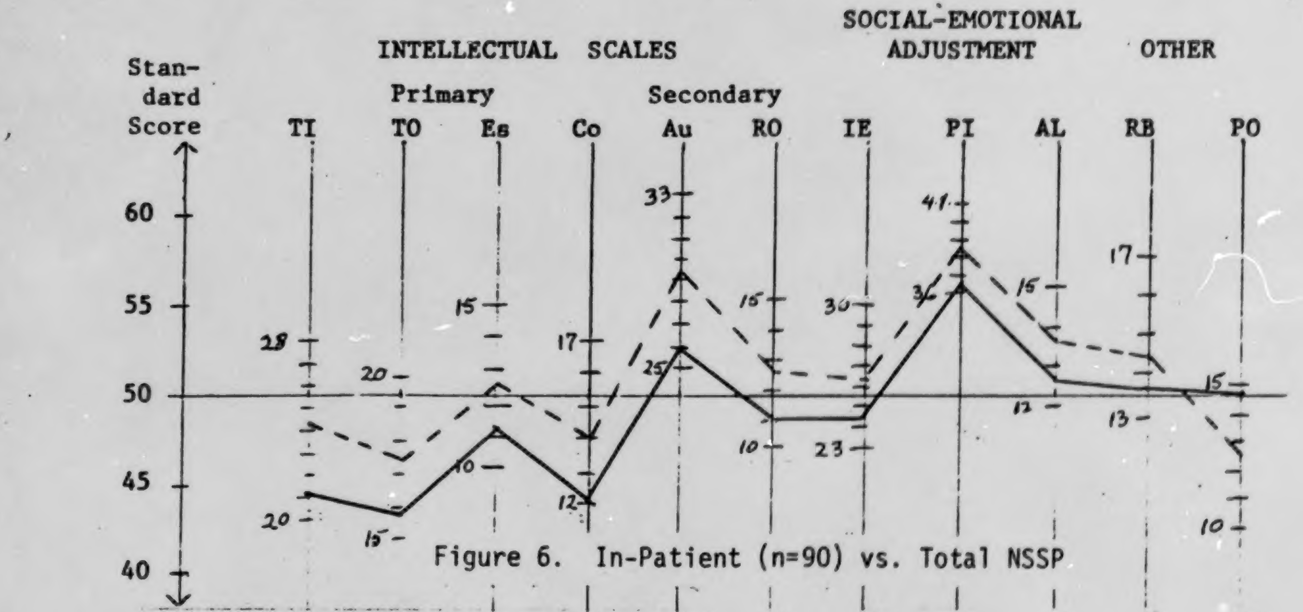

Figure 6. In-Patient (n=90) vs. Total NSSP

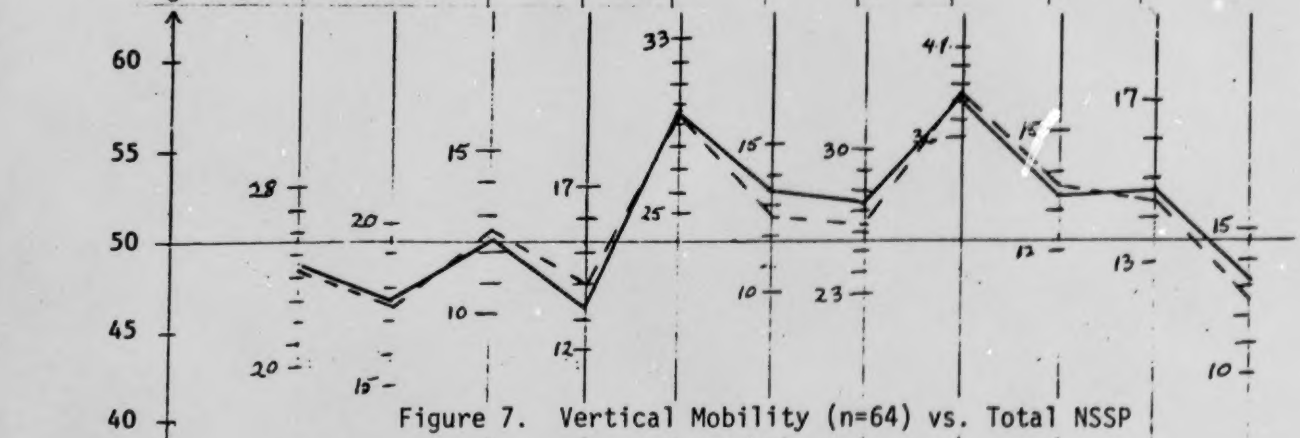

Figure 7. Vertical Mobility (n=64) vs. Total NSSP

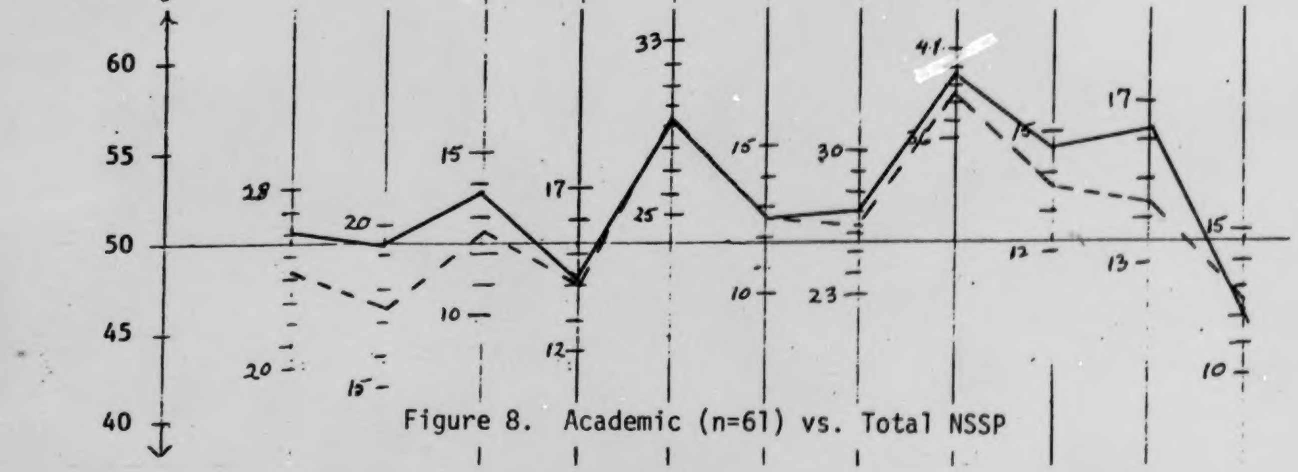

Figure 8. Academic (n=61) vs. Total NSSP

down-to-earth in comparison to other Second Step students. The fact that this personality profile so closely parallels that of the total population prompts an interesting observation: The whole idea of the Second Step curricular model is closely linked with the idea of "career mobility." The congruence we see may suggest that students who are entering these programs tend, on the whole, to have personality characteristics very like this small, select group who actually verbalized the importance of "getting ahead" in the profession. So from our observation that the V.M. group is similar in personality to the total group, we can hypothesize that the "vertical mobility personality" is one which seems to characterize Second Step students in general. In other words, the kinds of students these programs are recruiting are those whose personality structures are compatible with a desire to move into positions of influence and authority.

The Academic (Figure 8) display some interesting and interpretable similarities and differences. On three of the primary intellectual scales, they score considerably higher than the NSSP average--especially on Theoretical Orientation. They are definitely more intellectually disposed, although still close to the standardized mean of "college students" in general. But on Complexity (Co), they are at about the same level as everyone else. They, too, are not fond of ambiguous situations where there is no clear "right" and "wrong" answer. The other place where they part company from the herd is in indicating a noticeable tendency, as a group, to want to "make a good impression"--the RB scale. This particular characteristic may indeed serve them very well in their academic pursuits, where self-effacing modesty has never gotten anyone very far! Along with this, we see a striking lack of anxiety and nervousness (AL), perhaps because as academic types entering academic surroundings, they feel less threatened than others for whom the campus environment is one to be endured and gotten through rather than aspired to.

Figure 9 shows the Community Health personality which is almost a caricature of the overall Second Step profile--the high points are higher and the low points are lower. TI, TO and Co are all a notch below the NSSP average, denoting at best only a moderate degree of intellectuality.

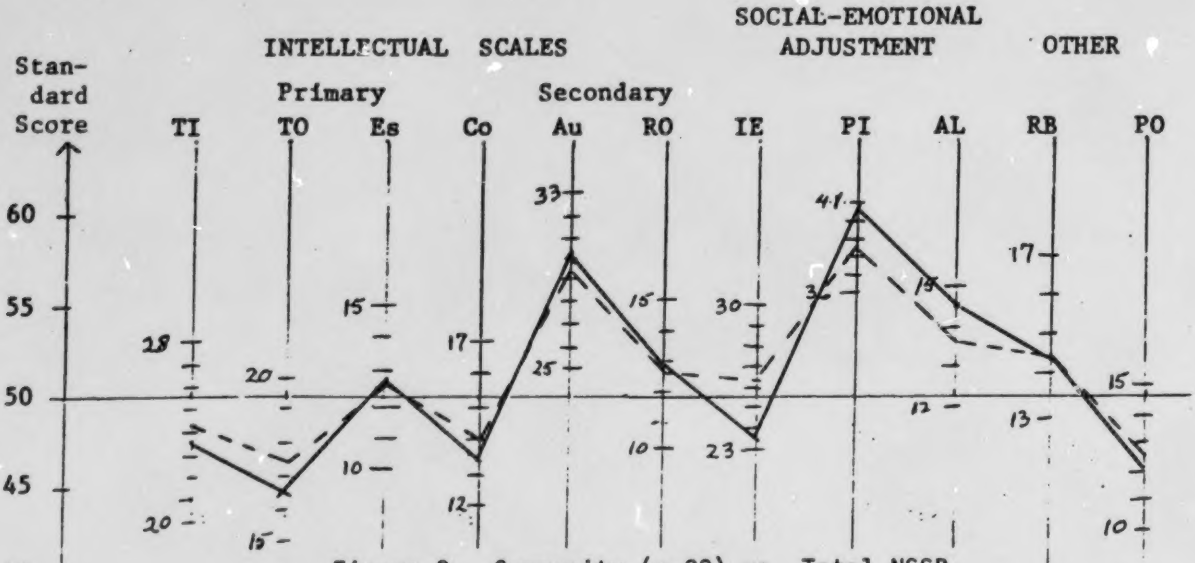

Figure 9. Community (n=93) vs. Total NSSP

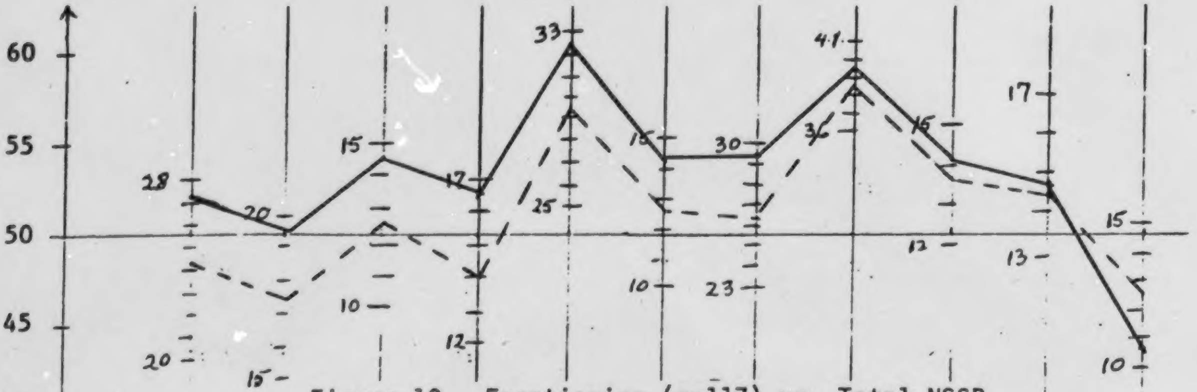

Figure 10. Frontiering (n=117) vs. Total NSSP

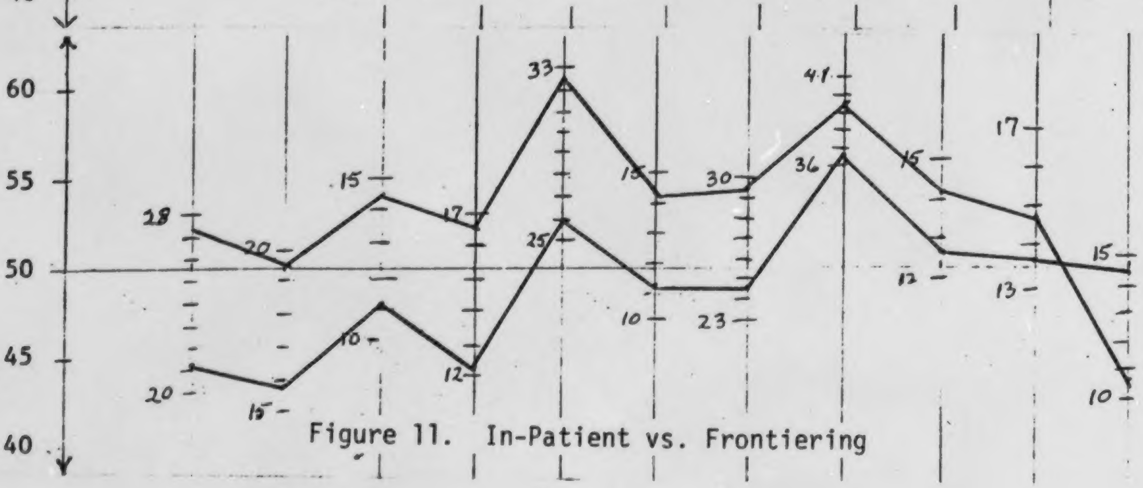

Figure 11. In-Patient vs. Frontiering

On the positive side, however, there is a remarkably strong mean score on Personal Integration; they accept and embrace both themselves and people in the world around them. Emotional disturbance and social alienation are simply not to be found here. AL indicates that they are not worriers; and in this configuration, the relatively low score on Impulse Expression (IE) would be interpreted as an indication of being well-controlled rather than impulsive or highly expressive--a trait which may serve them well in Community Health work.

The Frontiering profile (Figure 10) is obviously the most elevated on all six of the intellectual scales, although it stands equal with that of the Academics on Theoretical Orientation (TO). The most striking contrast, however, is on Complexity (Co), reflecting an experimental and flexible orientation rather than a fixed way of viewing and organizing phenomena. This particular trait is remarkably well adapted to the demands of frontiering nursing roles which are by definition neither well-established nor well-defined. They also display the highest degree of autonomy (Au), combined with fewer religious constraints (RO) and greater expressiveness, imaginativeness and impulsivity (IE). Finally, the PO score indicates relatively little regard for the practical approach and a certain de-valuing of material possessions and concrete accomplishments. In short, they look very much like the adventurers that you would expect to find on the frontiers of nursing practice, and who might be marvellously unsuited to the regimented setting of a metropolitan hospital unit.

Finally, let's look at the two end-points on our dimension of traditionalism: the traditional In-Patient vs. the non-traditional Frontiering orientation. The two personality profiles are totally distinct, but each may be best adapted to the needs and demands of its own careering aspirations. (Figure 11)

Many other variables, some of which are shown in Table 3, serve to further differentiate the five orientation groups. Significant differences on chi-square and analysis of variance indicate areas in which the sub-samples merely differ from one another; the Pearsonian correlation is significant only when those differences indicate a linear relationship with the concept of traditionalism as measured by nursing orientation.

Table 3. OTHER SIGNIFICANT (< .01) DIFFERENCES BY ORIENTATION

	Chi-Square	ANOVA	Pearson's r
External Measures			
Type of Program (Upper 2 vs. 2+2)	.000	N/A	.000 (+.32)
Intellectual Disposition Categories (OPI)	.000	.000	.000 (-.28)
Community Health Score (NLN Ach.)	N/A	.002	.001 (-.25)
Applied Natural Science Score (NLN Ach.)	N/A	N.S.	.004 (-.20)
Motivations: Qualitative Assessment			
Careering Goals	.000	.000	.000 (-.25)
Educational Goals	.000	.000	.001 (-.15)
Avoid Hospital Employment	.005	.001	.000 (-.20)
Self-Report Data from Students			
Political Liberalism	.000	.000	.000 (-.27)
Effect of Women's Movement on own Career	.000	.000	.000 (-.28)
Favors Major Social Change in Sex Roles	.001	.000	.000 (-.18)
Ratings of Present Health Care System	N.S.	.002	.001 (-.16)
Own Self-Concept (Nominal Categories)	.000	N/A	N/A
NSSP Indices			
Professional Interests	.005	.001	N.S.
Self-Perceived Competencies	.001	.000	N.S.

The single positive correlation is with type of Second Step program attended, indicating again (see Table 2) that traditionalism is much more likely to be expressed by Two-Plus-Two than by those in the Upper-Two programs. Negative correlations indicate that it is the less traditional groups who tend 1) to score higher on the NLN achievement tests as well as the OPI's measure of intellectuality; 2) to be motivated by careering and educational goals as well as by a desire to avoid hospital employment; and 3) to evince a related cluster of social attitudes: political liberalism, concern with sexual politics, and a decidedly critical evaluation of the present health-care system.

Looking at nominal categories not amendable to correlational analysis, various ideal self-concepts were differentially prevalent.

The In-Patient group sees itself as kind and helpful; the Vertical Mobility sample prefers a self-image of fame and achievement; and the Community orientation aspires to contentment and/or creativity. Neither the Academic nor the Frontiering group were distinguishable from the total sample on this measure.

Breadth and intensity of professional interests, as well as self-reports of competence, although significantly different among the five groups (chi-square and ANOVA) bear no significant relationship to traditionalism. On these measures, the Community resembles the In-Patient group in scoring lower, whereas the Vertical Mobility resembles the Frontiering and Academic groups in their higher scores.

In closing, let's look at a few of many variables which do not differ by orientation group (Table 4). No significant differences occur on a measure of general intelligence. All achieve similar grade-point averages, both in their first and in their final terms. And although the more traditional students are slightly more likely to graduate within two years, neither chi-square not ANOVA produces significant differences on this outcome variable.

Table 4. OTHER VARIABLES WHICH FAIL TO DIFFERENTIATE (< .01) AMONG ORIENTATION GROUPS AT ENTRY

	Chi-Square	ANOVA	Pearson's r
External Measures			
General Intelligence (Cattell's CFI)	N/A	N.S.	N.S.
First Term GPA	N/A	N.S.	N.S.
Cumulative GPA	N/A	N.S.	N.S.
Graduation Within Two Years of Entry	N.S.	N.S.	.01 (+.16)
Motivations: Qualitative Assessment			
Personal Goals	N.S.	N.S.	N.S.
Practical Goals	N.S.	N.S.	N.S.
Related to Second Step Curricular Model	N.S.	N.S.	N.S.
Self-Report Data From Students			
Willingness to Encounter Adversities	N.S.	N.S.	N.S.
Efficacy	N.S.	.01	N.S.
NSSP Index			
Commitment to Nursing	N.S.	N.S.	N.S.

Strong personal motivations, as well as those of a more practical nature, are equally represented among all five groups. Certain aspects of the Second Step curricular model are equally appealing across the board, bringing them into a baccalaureate program to upgrade their professional qualifications. All are equally willing to encounter adversities in the course of their work with patients and clients. Efficacy, or the sense of one's own ability to bring about change, discriminates only minimally among the five groups. Perhaps most important, all appear equally committed to the ideals and values of professional nursing, although the way in which they will express and embody that commitment may vary widely.

As educators, you might hope that all Second Step students were raving intellectuals, but I would urge you to take a broader view of what professionalism in nursing really means, and how it relates to the various kinds of role expectations, or professional orientations, that your students may represent. Look closely at the characteristics of your own curriculum, your own recruitment practices, and--perhaps most important--your own students. Then consider how best to build upon their strengths, to correct their limitations, and to enhance their potential for growth.

Notes

[1] Such items included the following: 1) interest in direct patient care; endorsement of 2) "dedicated service to humanity" and 3)"demonstrating care and concern for others in an immediate and tangible way" as important for the future of nursing; 4) lack of strong interest in being self-employed; and 5) a positive or neutral rating of today's health care system.

[2] The other three scales, on which no significant differences occurred, are 1) Masculinity/Femininity, on which this sample is understandably more "feminine," 2) Social Extroversion where they score at the standardized mean, and 3) Altruism which is relatively high among all Second Step students and all orientation groups.

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Appendix Table 1. Statistical data displayed in Figures 1 - 4

Variable and Categories	Sub-Samples					Total Sample
	Front	Comm	Acad	V.M.	In-Pt	
S.E.S.	%	%	%	%	%	%
Upper	25.7	33.3	47.3	26.7	30.4	31.5
Middle	31.2	41.4	27.3	40.0	38.0	35.6
Lower	43.1	25.3	25.5	33.3	31.6	32.8
x^2 sig=.0596						
r = -.05						
Sex						
% Women	92.6	99.0	95.3	90.8	97.8	95.2
x^2 sig=.0654						
r = -.03						
Race						
% White	90.8	86.1	87.0	92.9	90.9	89.5
x^2 sig=.6754						
r = -.03						
Religion						
Catholic	39.3	51.0	51.6	53.8	61.1	50.3
Protestant	45.9	39.6	46.9	41.5	30.0	40.7
Other	14.8	9.4	1.6	4.6	8.9	8.9
x^2 sig=.0044						
r = -.13						
Age						
19-22	8.3	16.8	14.1	22.2	52.8	22.3
23-28	37.5	26.3	32.8	33.3	19.1	29.9
29-34	30.8	25.3	17.2	23.8	15.7	23.4
35+	23.3	31.6	35.9	20.6	12.4	24.4
x^2 sig=.0000						
r = -.26						
Marital Status						
Never marr.	45.9	49.0	37.5	56.9	70.0	51.9
Married	37.7	35.4	42.2	32.3	22.2	33.9
Sep,Div,Wid	16.4	15.6	20.3	10.8	7.8	14.2
x^2 sig=.0086						
r = -.16						
Basic Program						
Assoc. Deg.	70.5	65.6	51.6	71.9	84.4	69.7
Diploma	29.5	34.4	48.4	28.1	15.6	30.3
x^2 sig=.0005						
r = -.02						

Appendix Table 1. (Continued)

Variable and Categories	Sub-Samples					Total Sample
	Front	Comm	Acad	V.M.	In-Pt	
Years Between	%	%	%	%	%	%
0-1	28.9	27.1	27.0	35.9	57.3	35.1
2-5	35.5	34.4	30.2	31.3	22.5	31.2
6+	35.5	38.5	42.9	32.8	20.2	33.7
x^2 sig=.0007						
r = -.17						
Add'l Cred.						
% None (±LVN)	89.3	89.5	85.9	90.6	95.6	90.4
x^2 sig=.4818						
r = -.03						
When Decide						
% Before RN	28.7	29.5	34.9	27.7	54.5	34.9
x^2 sig=.0006						
r = -.16						
Attend. Pattern						
Continuous	17.1	25.9	27.6	34.7	50.0	29.9
Some Breaks	23.8	20.0	17.2	22.4	20.5	21.1
Broken	59.0	54.1	55.2	42.9	29.5	49.1
x^2 sig=.0006						
r = -.25						
Member Orgzn						
% Yes	51.6	34.7	43.8	33.8	27.8	39.2
x^2 sig=.0048						
r = -.16						
Supv. Expr.						
% None	79.7	81.1	77.4	75.0	90.9	81.3
x^2 sig=.0980						
r = -.07						
Out-Pt Expr.						
% None	71.4	70.2	64.5	85.7	94.4	77.0
x^2 sig=.0000						
r = -.21						
In-Pt Expr.						
0-6 mos	17.0	28.4	22.4	40.4	51.2	30.7
7 mos-5 yrs	56.3	53.4	46.6	45.6	36.6	48.6
5+ yrs	26.8	18.2	31.0	14.0	12.2	20.7
x^2 sig=.0000						
r = -.24						

Appendix Table 1. (Continued)

Variable and Categories	Sub-Samples Front	Comm	Acad	V.M.	In-Pt	Total Sample
Tot. RN Expr.						
0-6 mos	14.3	23.0	17.2	38.6	49.4	27.3
7 mos-5 yrs	52.7	49.4	48.3	45.6	37.0	47.1
5+ yrs	33.0	27.6	34.5	15.8	13.6	25.6
x^2 sig=.0000						
r = -.27						

Appendix Table 2. Statistical data displayed in Figures 5 - 10 (Omnibus Personality Inventory)

	Sub-Samples					
OPI Scales	Front (n=117)	Comm (n=93)	Acad (n=61)	V.M. (n=64)	In-Pt (n=90)	Total NSSP (N=786)
	$\overline{X}$	$\overline{X}$	$\overline{X}$	$\overline{X}$	$\overline{X}$	$\overline{X}$
Thinking Introversion	27.1	23.7	26.0	24.5	21.2	24.1
Theoretical Orientation	19.4	16.8	19.4	17.6	15.9	17.5
Estheticism	14.4	12.8	13.7	12.3	11.2	12.7
Complexity of Outlook	16.6	13.5	14.2	13.5	12.2	14.0
Autonomy	32.3	30.2	29.2	29.7	26.0	29.3
Religious Orientation*	14.2	12.9	12.7	13.4	11.2	12.7
Impulse Expression	29.4	23.8	27.0	27.1	24.5	26.3
Personal Integration	39.3	40.9	39.5	38.1	36.7	38.6
Anxiety Level**	14.1	14.5	14.6	13.5	12.8	13.8
Response Bias	14.8	14.4	16.2	14.7	13.7	14.4
Practical Outlook	10.8	12.2	12.2	13.1	14.8	12.6

* RO is scored in reverse, so it is a measure of religious liberalism

** AL is scored in reverse, so it measures a lack of anxiety

THE SECOND STEP ENVIRONMENT:
INTRINSIC MOTIVATION VS. STRUCTURED LEARNING

Sally Brian

Numerous studies have been done in many disciplines which show a relationship between environment and behavior. Second Step programs as well as generic programs set goals for themselves. They universally wish to socialize their students into becoming professionals. This is done through the experiences students encounter in and out of classes and clinical settings, in the relationships between themselves and with faculty, and in the values, skills, knowledge and abilities they internalize and incorporate into their behaviors. The nursing school environment incorporates all of these factors. Therefore, information on how students and faculty perceive their environment is relevant to the mission of nursing programs. Environments are also mutable--effective and purposeful change should be preceded by rational information.

The most obvious external difference between Second Step and generic programs is the fact that all Second Step students are already RNs; they have passed their State Boards and hence possess enough knowledge to be considered safe to practice nursing. Does this basic difference translate into differences in the environments of nursing programs? If differences occur, why?

To measure these differences, we used the Nursing School Environment Inventory (NSEI) (Lysaught, 1971, pp. 465-71). This instrument was originally used as part of the study done by the National Commission for the Study of Nursing and Nursing Education; and hence, data exist on a large national sample of nursing programs. The NSEI is a direct derivative of the Medical School Environment Inventory (MSEI) created by E. B. Hutchins in 1962 to measure the perceived environment of medical schools. The original pool of 180 items was based on items from the College Characteristics Index (CCI) of George Stern and Robert Pace which has been used quite extensively to measure college environments. Factor analysis of these items resulted in six non-overlapping scales containing 69 items. The scales were shown to be quite reliable in measuring differences between schools (alphas ranging from .88 to .99). No similar data were reported for the NSEI. William Johnson in his doctoral dissertation simply made the assumption that the validity and reliability of the MSEI would hold for the NSEI used on nursing school populations (Johnson, 1970).

In the tests for construct validity in the medical school data, the Intrinsic Motivation scale proved the most stable over time. It correlated highly with various external factors measuring medical students' abilities, values and personalities. Other scales were related to some of these variables. However, the Academic Enthusiasm (AE) scale appears to be isolated.

The theoretical base for these instruments derives from George Stern's and Robert Pace's attempts to implement the work of the psychologist Henry Murray. They felt that a student's behavior will depend not only on his personality (needs) but on the demands of a college (press) and the interaction between the two. Two instruments were developed to measure these characteristics. The results of the data from studies using these instruments showed that the ways people's personalities differed was independent of the ways college environments differed. They also showed that participants do achieve consensus concerning characteristics of their shared environment, and that this consensus, as measured by the CCI, accurately reflects the objective environment.

William Johnson in 1970 used the NSEI for comparing the factor scores from both students and faculty at a representative sample of generic baccalaureate, AD and diploma programs. This paper will compare the results from our Second Step sample with Johnson's generic baccalaureate population. Faculty from AD, generic, Second Step and master's programs within the Orange County/Long Beach Nursing Consortium recently used this instrument and had mean scale scores remarkably close to those reported by Johnson (Orange County/Long Beach Nursing Consortium, 1980, pp. 18-20). The Sonoma State Demonstration Study (Jako et al., 1978) posits that the NSEI might be outdated, and that the startling results from that study of Second Step students[1] might merely indicate changing times and consequent changes in program goals, ethics and environments. Such reasoning, however, is contradicted by the recent Long Beach data.

Our current study consists of two samples: 68 faculty members from six Second Step nursing programs who completed the NSEI in 1979 and 569 second-semester Juniors from the same programs who completed the instrument in 1979 and 1980.

One of the goals of the NSSP is to determine if Second Step education exists as a unique model in nursing education. From the results of the data I will be discussing today, it appears that the environments in six Second Step schools, while not identical to each other, differ from the generic environments or from any other type of nursing school for that matter.

First, I will present a brief overview of the six environmental factors and compare the results between generic baccalaureate and Second Step programs. I will then examine each factor and attempt to explain the differences that occur.

The six factors measured by the NSEI are:

Academic Enthusiasm and Interest--the degree to which an environment is characterized by a high regard and enthusiasm for academic achievement.

Extrinsic Motivation--the degree to which an environment exerts pressures for group conformance to prescribed norms of behavior.

Breadth of Interest--the degree to which an environment reflects interests beyond the boundaries of nursing.

General Esteem--a general factor indicating the degree to which an environment is perceived as "good" rather than "bad."

Intrinsic Motivation--the degree to which an environment does not put pressure on students to achieve or to conform.

Encapsulated Learning--the degree to which an environment is characterized by clear-cut and tightly organized instruction, a closely prescribed curriculum, and a lack of emphasis on student initiative.

Figure 1 compares the difference of mean scores on each factor for generic and Second Step faculty and students. Using schools as the unit of measure since we are measuring the difference in perceived environments, we find that Second Step students and faculty are generally in agreement in describing their environments, except on the last factor, Encapsulated Learning. Generic faculty and students have greater differences in perception on four of the six factors. Students in Second Step programs differ significantly from students in generic programs on all six factors, and faculty in the two types of programs differ on four of the six. A t-test showed the last four factors for both groups are significant beyond the 1 in 10,000 level. Second Step students characterize their environment as possessing less extrinsic and far greater intrinsic motivation. They think well of their environment and feel that the interests go beyond nursing. However, they definitely perceive it as being structured.

Now I will discuss each factor in more detail and try to explain why some of these differences occur.

Academic Interest and Enthusiasm

High scores on this factor describe an environment where students seek academic excellence and the faculty is enthusiastic about subject matter. Second Step and generic faculty and students all place their programs near the middle of the possible range. Faculty in both types of programs endorse more of the items than students.

Three of the items on this scale relate to competition. Second Step students repeatedly have told us in other surveys that they do not like competition. On the NSEI, there is no consensus on whether or not competition in the environment exists or if it facilitates the acquisition of knowledge. Perhaps, the fact that students want to devalue and diminish competition interferes with even its recognition. Faculty do see students as competing with each other to a degree.

Among Second Step students, competition is not directly associated with academic achievement and interest. They feel they can achieve

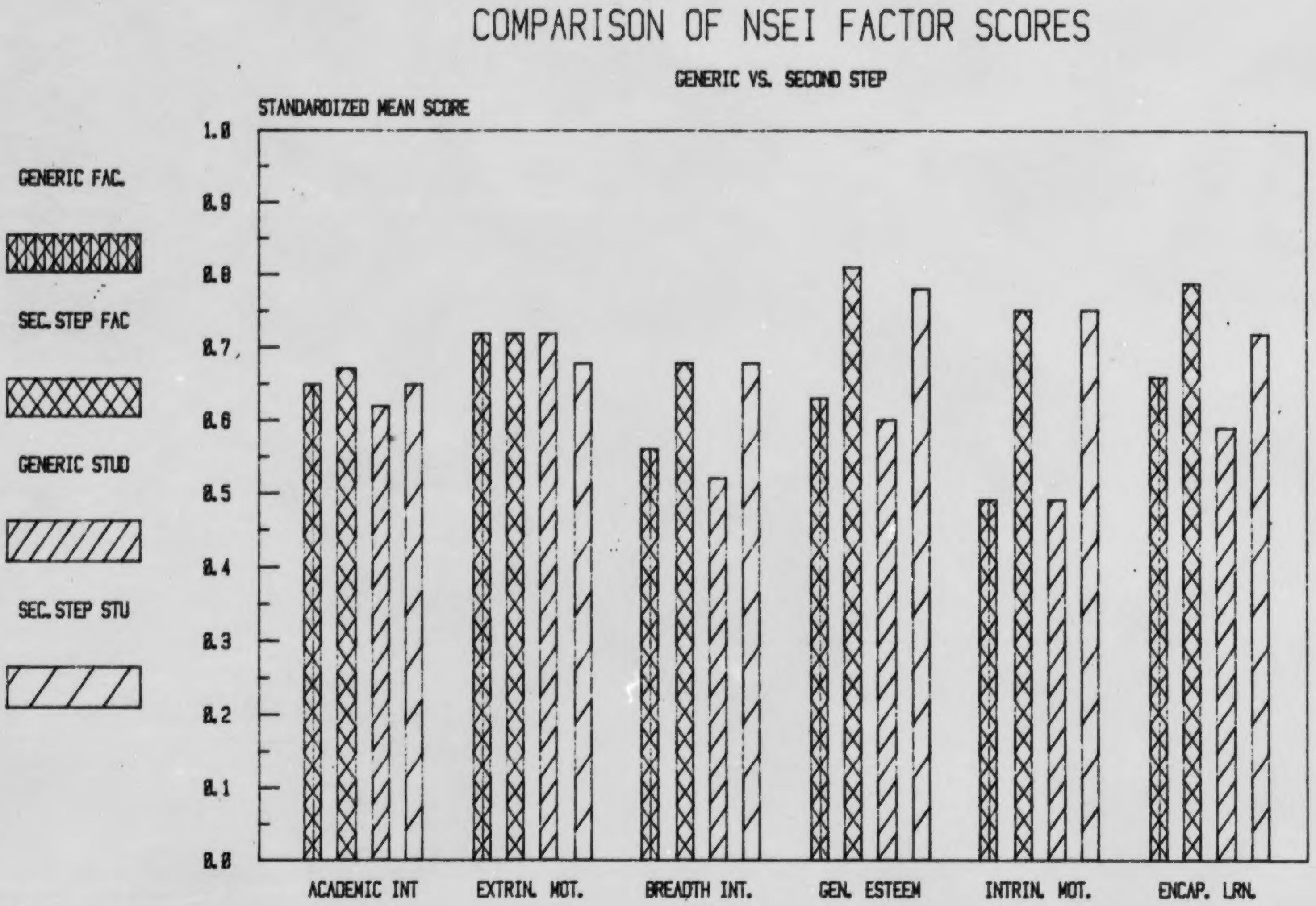
COMPARISON OF NSEI FACTOR SCORES
GENERIC VS. SECOND STEP
STANDARDIZED MEAN SCORE
1.0
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0.0
GENERIC FAC.
SEC. STEP FAC
GENERIC STUD
SEC. STEP STU
ACADEMIC INT
EXTRIN. MOT.
BREADTH INT.
GEN. ESTEEM
INTRIN. MOT.
ENCAP. LRN.

FIGURE 1

without competing since they have high academic aspirations. Eighty percent expect to receive at least a master's degree.

In data gathered from other instruments, Second Step students report that they receive a great deal of satisfaction from learning new ideas and that they expect that ideas will be quite important to them in their life after college, but they cannot be classified as intellectuals. The intellectual disposition of students as measured by the OPI is slightly below the mean for the normative sample of all college students. They however do expect that nursing of the future will be characterized by solid intellectual content. Taken together these responses show that there is a fairly good match between stated academic interests and the environment of the Second Step nursing programs.

Extrinsic Motivation

In the NSEI, the high end of this factor describes an environment with discipline. There is faculty pressure to achieve. Students are closely supervised by faculty and encouraged to work together to avoid clinical mistakes. Formal group structure among students operates to inhibit hostilities. A general climate of external motivational pressure is suggested. This is the only factor in the NSEI where Second Step students have a lower score than generic students. The two types of faculty have virtually the same EM score.

Given the fact that Second Step students are already RNs, close supervision would not appear to be necessary. Explicitly, these programs state that their students are adult learners ready to assume self-direction. With this philosophy, one would not expect to find an environment where many external pressures were necessary. Some, however, do exist and faculty perceive more of these than students.

However, both generic groups receive higher-per-item scores on the EM factor than any other. In other words, this scale is more descriptive of their environment than other scales. For the Second Step population, the EM scale ranks fourth.

Several items refer to students helping each other and being encouraged to work in small groups. In Second Step programs, the rationale for encouraging this behavior may not be the prevention of clinical mistakes but the facilitation of collaboration and the development of group dynamic processes.

During interviews held last Spring, some faculty stated that students felt forced to return to school by outside forces in the profession and that the students resented being told they needed more schooling, that their RN was inadequate. About one-fourth of the students volunteered that the threat of the mandatory BSN was a motivating factor for their baccalaureate, but seldom was this the only factor mentioned.

Several other items on our entry questionnaire relate to the concept of extrinsic motivation for academic achievement. Students generally do not prefer their professors to check up on their work and are neutral as to whether attendance should be required or whether they work alone or in groups on projects.

Breadth of Interest

This factor describes an environment where students and faculty share interests beyond nursing in the philosophy of science, the behavioral sciences and social activities. Second Step students and faculty have the same mean score for the entire scale and are quite close on each item making up the scale. But the difference in mean scores between generic and Second Step programs is large. Second Step students score 1.33 standard deviations above the generic mean. The Second Step population had no single item score on the scale as low as the mean score at generic institutions. Second Step scores are not very high--mean per item of only 2.7 out of a possible 4. Generic scores are just extremely low, averaging 2.0 per item. Generic students and faculty describe their environment as primarily concerned with nursing without much interest in other areas. Perhaps the fact that neither student nor faculty in Second Step programs need be concerned with passing State Board exams allows them the leeway to begin to be interested in things outside of pure nursing.

To me, this factor says a lot about nursing education. I think I would be very hard pressed to find one nursing educator in an institution of higher learning who would disagree with the statement that nurses should have a liberal education. However, we find that traditional programs are limited in breadth. Second Step programs fare somewhat better in actually fostering an environment where a greater breadth of interest is possible.

We have seen in the Sonoma State Demonstration Study and in the National Second Step Project that students come into the program moderately interested in courses and areas outside nursing; but as they progress through the program, this interest heightens. In the First Year Survey given concurrently with the NSEI, students overwhelmingly respond (89%) that it is important for nurses to take courses in other departments. However, almost one-fifth do not plan to take any non-nursing courses during their senior year. Generally, they feel that the nursing students are too isolated from the rest of the campus and should participate more in campus activities. But they don't necessarily translate these feelings into actions to rectify the problem.

Neither faculty nor students show a consensus of views on whether the environment of the nursing school stimulates interest in things other than pure nursing. The data indicate that the students at least recognize that they should have interest in other areas.

General Esteem

General Esteem, the largest NSEI factor, consists of 23 items measuring the clearly good or bad things about the nursing school environment, exemplified by a holistic view of nursing, cordial faculty-student relations, a regard for intellectual pursuits, and an institutional concern for the students and their problems.

The Second Step population score highest in items relating to comprehensive patient care. These items are followed in emphasis by the perceived relevance of the teaching and education to the practice of nursing, and the hard-working, committed nature of the students. Items related to advising and counseling receive the lowest student mean score and show the most discrepancy between student and faculty viewpoints. Faculty perceive themselves as doing a good job in advising, counseling and being available to help students plan their careers. Students are far less sure of the faculty's competence and performance in these areas. Perhaps, the results just represent human nature--faculty feel they are doing as well as they can and students want more than they are getting.

Overall, both faculty and students in Second Step programs rate General Esteem substantially higher than generic baccalaureate faculty and students. In fact, the school means for the Second Step programs are almost four standard deviations above the mean for the generic programs. Not one item of the 23 which make up the GE scale falls below the mean achieved for the entire scale by generic students or faculty.

It is difficult to explain these extreme differences. Since generic baccalaureate programs must teach the basics of nursing, they are still perceived as dealing primarily with the physical aspects of nursing. Students in Second Step programs presumably already know the basics so are ready to go on to other things, allowing the programs to truly stress comprehensive patient care and treatment of the patient as a whole. Even though many generic programs today may claim to teach all aspects of nursing--the psycho-social-cultural as well as the bio--the emphasis may still be primarily limited to the physical.

Several items in this factor measure the practical relevance of the program. Why Second Step programs are perceived as being more practice-oriented is even more perplexing to explain. Perhaps, the student's experiential base allows them to select from the information that is presented and appropriately apply what they are learning to their previous background. Since they can relate the theories to their own experiences, they feel that what they learn will be very relevant to their potential practice. The Second Step programs apparently are taking their mission of teaching adult learners seriously, providing an atmosphere which allows them to freely translate between theory and practice.

The biggest surprise on this factor is not that the scores for the Second Step students and faculty are so high but that the generic scores are so low. Apparently, changes within the profession during the last ten years do not supply an adequate explanation. Faculty within the Long Beach Consortium for Nursing Education recently achieved a mean score only slightly higher than scores received a decade ago. Their scores are still over two standard deviations below the mean score for the Second Step faculty.

Intrinsic Motivation

If any measure shows that Second Step programs have a different environment than generic programs, this factor does. Using school mean scores for students, Second Step programs score 4.4 standard deviations above the mean; and faculty score 6.7 standard deviations above the mean. I don't think I need to say that these numbers are statistically extremely rare. No nursing program in the original sample had a mean score as high as a Second Step program. Indeed, the lowest individual score was almost as high as the highest school mean score in a generic program!

The Second Step scores are uniformly high, averaging about three points out of a possible four per item. The generic scores are much lower, averaging less than two points per item. This factor shows that faculty do not regularly check up on students by requiring an assigned seat or giving unannounced or frequent tests, that there are many opportunities for individual creative activity and that they feel their school is outstanding for emphasis on student scholarship and research. However, students prepare for exams together and feel that their instructors expect them to take comprehensive notes in lectures. Both of these items would cause the overall factor score to decrease.

High factor scores for intrinsic motivation certainly seem appropriate for these programs. These students have very high Autonomy scores on the OPI; they generally feel good about themselves as evidenced by the high Personal Integration and Anxiety Level scores. They are also motivated. They made a conscious decision to return to school, often predicated by a decision to make changes in their careers. Often they express a personal, inner motivation as important in their decision to return to school. Age and experience appear to be related to these scores, but the scores at the 2 + 2 programs where most students continue straight through for four years are just slightly below the upper two programs.

As they enter the programs, students show an awareness of the importance of informal independent study and research as well as reading independent of classes. These endeavors grow in importance as they progress through the program. Apparently, students maintain their intrinsic motivation for learning and feel their Second Step environment fosters this motivation.

Clear, Concise Encapsulated Learning

This factor measures aspects of the environment in which instruction is well organized with little divergence from the prescribed curriculum. Students know in advance what is expected of them enabling them to plan their studies accordingly. Faculty infrequently wander off the topics at hand.

The Second Step programs's high scores on this factor could potentially create some conflicts with high scores on intrinsic motivation. Students may function somewhat independently, but the limits of their independence is prescribed.

The relatively low scores on Complexity of both faculty and students may help explain the prevalence of high scores on this factor. On the OPI, Complexity measures a willingness to deal with ambiguities, an appreciation for not having everything set out in advance. Most of you would agree that these are necessary qualities for one to function as a true professional. But nursing educators express a great desire for unity and continuity. They feel nursing is lacking because it does not have its own body of knowledge. Perhaps they, therefore, feel it is incumbent upon them to force order and structure onto the discipline by tightly prescribing their curriculum, goals and objectives.

Students often feel they are getting double messages. They are told they must learn to think independently, assess the complexities of a presenting situation and make or carry out appropriate decisions. However, in their school environment, they are told precisely what they should know and often feel confined by the amount of structure around them.

On this factor, faculty score substantially higher than students. They are aware of the structures they impose; and judging from interview comments, they feel compelled to impose the structure. When one faculty was asked if all students should be taught the same material in community health, she replied that the content should be standardized, "it never occurred to me to do it otherwise."

Perhaps a contributor to the reality shock we hear so much about is the conflict between the structured school situation, where students have a clear idea about what is expected of them, and the vague, broad policy guidelines that develop in complex work environments, the amorphousness of the institutions' policies and values (Benner and Benner, 1979).

In summary, we noted differences between the generic and Second Step environments in each factor, many of which can be directly attributed to the nature of the RN student--an experienced, older nurse who most likely made a very conscious and often costly decision to return to school for more education. Second Step environments can be characterized as being moderately academic but not very competitive, as putting some external pressures on the students but where motivation most often comes from within the individual as fostering an involvement in some areas outside nursing, as being seen as practical and holistic, and as treating students as adults. However, they are also seen as being highly organized and structured.

Adult learners have been described as persons growing in self-direction whose orientation to learning has shifted from subject-centeredness to problem-centeredness (Muzio and Ohashi, 1979). Maslow defines the fullest achievement of adult development as self-actualization--enjoying responsibility, liking to do things well, preferring to work toward one's own causes, interest in solving problems, refining and/or improving methods and setting things right (Maslow, 1971, pp. 308-09). The explicitly stated goals of Second Step programs include the development of all of these traits. But can these be fully accomplished in an highly structured environment? Are there times when extraneous material, thoughts and behaviors are productive? Gretta Styles, in a thought-provoking essay entitled "Serendipity and Objectivity," stated: "I believe that, even in a formal training program, the larger part of the learning may be unplanned and unanticipated, that actual learning may far surpass the instructor's ability to forecast or measure. I posit that the serendipitous harvest may be lush and lasting, and that serendipity should be cultivated in the educational process" (Styles, 1975). Much of the structure in nursing programs comes from carefully, often meticulously defined behavioral objectives. Can one truly define self-actualization in measurable outcomes? Should one even try? And could the resulting objectives actually limit and forestall the development of the desired and preferred individual traits? I would like to conclude with another quote from Styles:

> If learning is the product of a rich, extensive and maximally available perceptual field, and if heavy doses of concentration and threat limit the field, then should not our primary functions as teachers be (1) to create an ambience in which the learner feels good about himself, and (2) to expose him to a wealth of stimuli and assist him to explore their meanings. (Styles, 1975, p. 312)

As we have seen in this study, the Second Step environment goes part of the way in creating this ambience, but could possibly stand to loosen up and allow for more serendipitous learning.

Notes

[1] These "startling results" are discussed in the final report of the Demonstration Study (Jako et al., 1978) on pages 143-150. Supporting data are in Appendices M and N. The report is available through the National Technical Information Service. The three NSEI scales on which Sonoma State students scored more than two standard deviations above the standardized mean were General Esteem, Breadth of Interest and Intrinsic Motivation.

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LEADERSHIP IN SECOND STEP PROGRAMS:
PROBLEMS AND SOLUTIONS

Mary Searight

For the past 25 years, higher education in nursing has failed to provide an adequate number of prepared nursing administrators. The literature suggests three major reasons for this problem: 1) clinical emphasis at the master's level to the exclusion of a functional area such as administration (Blair, 1976); 2) highly sophisticated management systems requiring increased expertise (Arminger, 1976); and 3) growing numbers of new programs requiring more qualified administrators. As a result, a dearth of nursing education administrators exists at a time when increasing numbers of better-prepared administrators are required to meet an expanding need.

The phenomenal growth in Second Step programs requiring increasing numbers of administrators has contributed to this problem. These programs, specifically developed to assist registered nurse graduates of associate degree and diploma programs with the attainment of a baccalaureate degree, are characterized by an upper division curricular design which builds on work completed prior to licensure. They are non-traditional in that (1) they do not follow the established pattern of one to two years of general education followed by two or more years of nursing, and 2) they provide post-licensure rather then pre-licensure baccalaureate education. Not only is the curriculum non-traditional in design, but many of the programs have been initiated in institutions where a nursing major had not previously existed.

As an administrator of a Second Step program, I have been asked by potential planners of such a program, "What qualifications should we look for when we recruit the director of our proposed program?" I have answered, "Try to find a capable administrator with a doctorate (knowing the NLN criteria well), someone with teaching experience and knowledge of curriculum development, a person who works well with people"--meaning that they can get along well with the institution's administration, the nursing faculty and students, "a good public relations person who can cultivate the community at large and secure the clinical facilities the program will need." Because the proposed budget is usually exceedingly slim, I might add, "Someone who is a cracker-jack at writing grants would be nice." And on and on, knowing all the time that the likelihood of finding such a person is practically nil; and quietly thinking, "Lots of luck."

Not many people are academically and/or experientially prepared to meet those qualifications. Of those who do, most are already employed or have never been involved in establishing a Second Step program. Research related to the role and functions of all educational administrators is extremely limited; and on the subject of Second Step program administrators, it is non-existent. Actually, while we talk a great deal about administrative or leadership style, we know very little about how one's style relates to a job to be done.

These circumstances and problems led to my study of leadership among administrators of accredited and non-accredited baccalaureate programs for registered nurses only. The leadership styles of administrators who have been successful in planning and developing a Second Step program and achieving NLN accreditation had not been explored, and few criteria exist for the selection of an administrator to provide leadership for such a program.

Because the Second Step concept is non-traditional, there are also few guidelines to program development. Even the criteria for accreditation were developed with generic baccalaureate programs in mind. Planning and developing a new program requires the attainment of a multitude of goals and involves a continual process of situational assessment and decision making, but one high-priority goal for new programs is the achievement of NLN accreditation. Initiating a program and securing students appears as less of a problem than gaining accreditation. A 1978 survey conducted by the National Second Step Project showed that approximately two-thirds of Second Step programs seeking initial accreditation had been denied (Church and Brian, 1980). Lack of accreditation poses serious problems for both the institution and the student. Thus, great challenges are faced by an administrator in planning and developing such a program. While situational components, such as institutional and community support and monetary and personnel resources, may be very important, prior research suggests that a leader's style of behaving in a given situation most often determines goal achievement (Fiedler, 1967).

Leadership may be defined as the process of influencing the activities of a group toward the attainment of a particular goal in a given situation. Thus, we must consider the interaction between the leader and the group--in this case, the administrator and the faculty--in the process of achieving that goal. Stogdill suggests that it is not difficult to find leaders, but it is quite another thing to place these people in situations in which they will be able to function effectively (Stogdill, 1951).

My study of leadership in Second Step programs addressed the following questions: (1) How is the behavioral motivation of the administrator related to the achievement or non-achievement of NLN accreditation? (2) How does the extent of a leader's control and influence in a given situation relate to the achievement or non-achievement of accreditation? (3) What is the relationship between the administrator's prior education and experience and the program's achievement or non-achievement of accreditation? (4) Which, if any, of a number of potential problem areas created actual difficulties for these administrators in their quest for accreditation? Why were certain areas problematic, and how were they dealt with?

Methodology

A review of the literature revealed some tangential research and an abundance of speculative writing related to leadership behavior among nursing education administrators, but nothing that would form the basis for explicit hypotheses suitable for testing. Under these circumstances, an exploratory research design was chosen.

I used an experience survey to gather information which did not exist in written form. Only seasoned practitioners could provide that information. Every day, in the process of discharging their responsibilities, nursing education administrators make decisions, analyze the results, and choose further courses of action. What works and what does not work under certain circumstances crystallizes into a repository of wisdom that can be gathered and synthesized by means of an experience survey.

For this method, the duration of one's experience was obviously crucial. Our NSSP data identified those Second Step administrators who had held their positions in the same program the longest. And since the nature of that experience would be quite different depending on whether or not NLN accreditation had been achieved, the sample was also designed to include leaders who had and had not achieved accreditation. Therefore, the selection criterion of "experience" was measured by the number of years served as chief administrator of the same accredited or non-accredited Second Step program.

Using that criterion, the five most experienced administrators were selected from 11 Second Step programs which were accredited as of the Fall of 1978; and the five most experienced administrators were selected from 11 programs which at the same date had applied but had been denied accreditation. The total of ten respondents, all of whom agreed to participate, represented programs in eight different states.

Fiedler's contingency theory of leadership provides a well-documented framework, based on two major tenets. (1) Leadership effectiveness can be measured by how well the group being led achieves its goal. (2) Group performance is contingent upon both the behavioral motivation of the leader and the favorableness of the situation in which she/he operates. It is important to understand the terminology in that second proposition.

"Behavioral motivation" is used more or less interchangeably with "leadership style." Leaders, as individuals, have a motivational system consisting of behavioral preferences which reflect an underlying need structure. In Fiedler's terminology, leaders are either "task-motivated" or "relationship-motivated," and these are enduring characteristics of individuals regardless of the situation in which they find themselves

(Fiedler, 1967).

"Situational favorableness," or the degree to which the leader has control and influence, is determined by three components of the situation:

1) Leader-Member Relations--how much loyalty, assistance, acceptance, etc., does the leader feel s/he is getting from the group?
2) Task Structure--does the leader perceive relatively clear-cut goals, as well as an accepted and verifiable procedure for achieving them?
3) Position Power--what strategies does the leader perceive as available for implementing authority and/or decisions (supervision, evaluation, rewards, punishments, etc.)?

According to Fiedler's theory, it is the interaction of these two components (behavioral motivation and situational favorableness) upon which the quality of the group performance is contingent. He speaks of the "match" between the two as being more important than either one considered separately. Leaders with a task-motivated style excel when situational favorableness is either high or low. Relationship-motivated leaders perform best when situational favorableness is moderate. Instruments have been developed and tested to assess all of these components, including the "match" or "fit" between style and situation (Fiedler et al., 1976). It should be noted at this point that the tool to measure situational favorableness specifies the "situation" itself in terms of one particular responsibility undertaken by all respondents in their leadership roles. In this study, that responsibility was to produce the program's Self-Evaluation Study document preparatory to the NLN accreditation site visits. Thus adapted, these instruments were administered to all respondents, along with a questionnaire pertaining to prior education and experience.

Additional qualitative data were collected through an extensive taped interview focusing upon eight potential problem areas frequently encountered by academic administrators. Derived from previous studies, those areas were: (1) budget, (2) community service and relations, (3) curriculum and instruction, (4) faculty, (5) student affairs, (6) institutional policy making, (7) research and (8) professional responsibility

(Stanton, 1976; Zehr, 1976). In each area, respondents discussed the nature of the difficulties they had experienced and how they had dealt with them. They were also asked to rank the problem areas in order of severity, and to speculate as to why certain areas had been relatively trouble-free.

As implied in the research questions (see page 45), one basic intent of the overall analysis, both quantitative and qualitative, was to discern what differences might differentiate between the two sub-samples--leaders who had achieved accreditation and those who had not. When appropriate, frequencies and percentage distributions were used to describe coded variables, and non-parametric statistical techniques (chi-square and Kolmogorov-Smirnov) were used to determine the significance of a difference or a relationship. A more general purpose, however, and one more in keeping with the exploratory nature of the design and the particular strengths of an experience survey, was to provide hitherto unpublished information on the nature of these positions and the nursing leaders that inhabit them--their leadership styles, the difficulties that they must face, and the problem-solving strategies that they employ.

Findings

This study of Second Step program administrators revealed a number of interesting observations and insights. No differences existed between the two accreditation sub-samples in terms of formal education; in each group, three held doctorates and two held master's degrees. Those who had achieved accreditation had a greater accumulation of relevant administrative experience, although the difference was not statistically significant. The two groups identified the same problem areas during program development and preparation for NLN accreditation, and they gave the same reasons for why certain areas were troublesome.

Looking to the concepts of Fiedler's contingency theory, similarities between the two groups continue, but only to a certain point. No significant differences were demonstrated in behavioral motivation, both sub-samples being about evenly divided between task-motivated and relationship-motivated leaders. Each administrator was obviously operating in her own unique "situation" vis-a-vis her own faculty and the task at hand--that of developing a Second Step nursing program and achieving NLN accreditation. Even so, the two groups placed similarly high on two of the three components of situational favorableness: both indicated good leader-member relations, and both scored high on position power, suggesting that they feel they have adequate means at their command for implementing their authority and their decisions.

However, on the third component of situational favorableness, the perception of task structure, a significant difference was obtained between the two sub-samples. The scale for Task Structure measures (1) goal clarity, (2) goal-path multiplicity, (3) decision verifiability and (4) decision specificity. Faced with the necessity of compiling the Self-Evaluation Study document and carrying out other related activities in preparation for NLN site visitors, leaders of accredited programs were more likely to perceive a guiding "structure" to the task rather than a diffuse (and perhaps overwhelming) list of "things to do." This statistical finding was further validated in the interview data which will be reviewed in later sections of this paper. Although both sub-samples emphasized essentially the same problem areas, the manner in which they dealt with those problems differed noticeably.

As mentioned earlier, it is the interaction between the leaders style (behavioral motivation) and elements of the situation (situational favorableness) that, according to Fiedler's construct, determine the overall outcomes in terms of group performance and, therefore leadership effectiveness. When situational favorableness was adjusted for differences in educational or experiential preparation and then paired with behavioral motivation, a favorable match was obtained for all of the administrators who had achieved accreditation, as compared with only two of the non-accredited group. When situational favorableness and behavioral motivation find a "fit," both the leader and the group should do well; and in this study, that prediction was borne out.

It was not within the scope of this study to explore how or why these matches occurred. No evidence supports the notion that such matters were considered in the selection and employment of any of the administrators, and my assumption is that the fortunate match occurred through chance. Nonetheless, the findings do suggest that the administrators who achieved accreditation may have been more successful in finding ways to restructure their situations in order to produce a more favorable environment.

Let us turn now to a review of findings that emerged from interviews with these Second Step nursing leaders. The eight potential problem areas comprised the major categories of data for analysis. Responses related to each problem (or non-problem) area were recorded, divided according to accreditation status, and analyzed to see if there were noticeable differences in how problems were perceived and handled by the two groups of administrators.

Although this qualitative analysis was carried out independently of the quantitative analysis of data from the Fiedler instruments, certain parallels began to be visible between the two sets of findings. In their approach to various problem areas, and congruent with their higher scores on the Task Structure scale, administrators who had achieved accreditation appeared to be more certain of what had to be done, how and when. They discriminated more clearly between the most and the least important problem areas, concentrated their efforts on a given set of problems, found numbers of alternative solutions to individual problems, and appeared to have a sense of what was or would be effective. Their followers, the faculty and staff, seemed to respond more positively, became more productive, and were willing to work with the leadership provided. By contrast, and similarly congruant with their lower scores on Task Structure, administrators of non-accredited programs appeared less sure of what to do, how and when. They made little differentiation between the most and the least important problems, showed a tendency to negotiate and wait, or passively accept conditions as they were, and they more often relied upon the faculty for support. This uncertainty often caused delay in the identification of problems, required the leader to create or hunt for solutions, necessitated the development of evaluation tools to determine the effectiveness of action taken and delayed the application of appropriate solutions. The findings suggest that when both the goals and the legitimate procedures involved in an important task are perceived as vague and lacking in structure, the leader was more dependent upon the followers.

The major purpose of the interviews, however, was not merely to "compare and contrast" the two sub-samples, but rather to absorb some of the accumulated wisdom of these seasoned administrators of Second Step programs. In the remainder of my text, I will present an overview of some of the more salient points that emerged from those discussions.

In the sample as a whole, certain problems were more widespread than others. All ten administrators, for example, had experienced problems with faculty. Eight mentioned budget, curriculum and instruction, and student affairs; and seven found research problematic. Four had problems with community service and relations and instructional policy making, and only one had problems related to professional responsibilities. Here are some of the things that I learned.

Faculty. In a large part, the reasons given by all administrators for problems related to faculty were the same. Some mentioned difficulty in obtaining faculty with appropriate academic preparation, with enough teaching and clinical experience, or with a knowledge of curriculum development. Frequent turnover was also a problem which, in turn, required repeated training and orientation for new faculty. Undesirable geographic location and low salaries were mentioned as deterrents to securing faculty. Not only was expertise, or quality of faculty, seen as a problem but most administrators had difficulty in simply obtaining sufficient numbers. Faculty workload was considered heavy, and there was often little or no release time available for program development or for research.

Finding sufficient numbers of qualified faculty at a price the institution could afford was a common problem. Solutions took a variety of forms but with few distinctions between methods used by administrators of accredited and non-accredited programs. Vigorous recruitment, faculty development and action to increase salaries were employed to some extent by both groups. Only one administrator of an accredited program had enough applicants for faculty positions to be highly selective.

Budget. Only one administrator from each group said budget was not a problem. In both instances, the administrator had been successful in securing extramural funding to supplement that provided by the institution. The prevailing reasons for budgetary problems were lack of funding for program development, inadequate money to secure the faculty positions and expertise needed, no release time and heavy work loads. The availability and utilization of grant money constituted the major difference in approaches to budgetary problems made by the two groups. In the accredited programs, extramural funds not only provided an extra cache but also afforded more flexibility and autonomy in the expenditure of those monies. The non-accredited programs had either been unsuccessful in securing funds or had received insufficient amounts. Except for this dissimilarity, members of both groups took corresponding actions. Some used direct routes by "demanding more positions" or by "taking it to the legislature." Others took more of a middle-of-the-road tack by "requesting and negotiating." Still another approach was a passive role--requesting and believing that "it will come to pass."

Curriculum and Instruction. Eighty percent of the administrators of both accredited and non-accredited programs viewed curriculum and instruction as a problem. Reasons given centered around difficulty in designing a curriculum for which no guidelines existed, gaining consensus among faculty about curricular content and methods, a lack of expertise among faculty regarding curriculum development, and revising and reworking the curriculum to meet the criteria for accreditation. Both groups blamed faculty for problems in curriculum development. In addition, administrators of non-accredited programs suffered from lack of continuity due to untimely resignations, grievances and interpersonal problems among the faculty.

Solutions to the problems in this area were also similar. The use of consultants was common to both groups, but the problems associated with a lack of guidelines for curriculum design was approached much more directly by administrators of accredited programs. One had a very clear idea about what she thought the curriculum should be and took a strong, self-confident direction, rather like "I am the leader, and I know how it should be." Another took the "Yea, team" route, becoming the teacher of the faculty and actively soliciting their commitment and support. In three of the accredited programs, an initial denial or deferment of accreditation and subsequent recommendations from the NLN Board of Review had been used as guidelines for revising their curricula.

By contrast, administrators of non-accredited programs tended to take on a more passive approach, and there was little evidence of their direct participation in the area of curriculum and instruction. One expressed reluctance to change the curriculum because of "philosophical reasons," and another was "working it out." Most were discouraged and overwhelmed at times by the continuing burden of revision.

Student Affairs. Student affairs was considered problematic in all of the non-accredited programs and in most of the accredited programs; the nature of the problems were the same. All had difficulty in getting students involved in programatic and institutional committee work, student organizations and social activities. All admitted that a large part of the problem was related to the nature of the registered nurse prototype student--employed adult, spouse and/or parent trying to accommodate a new and demanding role within an already overcrowded schedule. Difference between the two groups in how they dealt with these problems were more a matter of degree and timing than of action taken. Administrators of accredited programs offered more alternatives in their approach to the students' lack of interest and involvement. Emphasis upon student organizations, social activities and open communication was more evident in their conversations. Administrators of non-accredited programs changed schedules and opened their meetings and committees to students but otherwise offered few solutions.

Research. Deficient funding, no release time and a lack of institutional emphasis upon research as a scholarly endeavor or as a criterion for promotion were given as causes for problems in this area by 60% of the administrators of accredited programs. The same reasons, plus limited expertise among faculty for conducting research, were given by 80% of the administrators of non-accredited programs. Administrators of both accredited and non-accredited programs used similar approaches to dealing with the problem. Both groups worked to obtain release time and/or money through extramural funding to buy release time for faculty research activities. Neither group had a viable solution to the lack of institutional emphasis on research, and only one administrator from an accredited program took a hard stand on requiring the doctorate for tenure. Those who did not identify a problem with research were involved in their own research.

The remaining three areas, community services and relations, institutional policy making and professional responsibility, were less problematic. Only 40% of both groups had problems with community services and relations. These related to securing clinical facilities and creating a favorable image for their program. Both groups approached these problems by explaining a lot, involving the community in the activities of the program. They carefully nurtured their resources so that the problems were either solved or noticeably attenuated. Relatively few problems associated with the function of institutional policy making were identified by administrators of either accredited or non-accredited programs. Those mentioned were policies regarding faculty salaries, defining institutional policy and its relationship to the nursing program and the establishment of policies regarding student admission. They dealt with these problems by becoming involved in policy making bodies such as the senate and faculty affairs and budget committees. They achieved good working relations with colleagues outside their departments, adapted existing policies when practical to do so, and took assertive action to change policies which hampered the development of their programs.

Essentially, professional responsibility was not a problem to either group. All of the administrators viewed participation in local and national professional organizations, attendance at professional conferences and workshops, and keeping current in their professional area of expertise as an established way of life.

Interview data related to problems encountered by the administrators during program development and preparation for NLN accreditation revealed similarities between the two groups as to: (1) which functional areas presented difficulties, (2) the reasons given for why they were problematic, and (3) which were considered the most problematic. Differences emerged, however, in how the problems were handled. Although the particular kinds of strategies eventually employed in dealing with the problems were very similar, administrators of programs which received accreditation tended to act on the problems earlier, to expend greater intensity of effort, and to generate a greater number of alternative solutions in a given situation.

Recommendations

Based upon these findings, I will make some recommendations. This is done with the full recognition that mine was a small sample. Whatever one's behavioral motivation--task oriented or relationship oriented--some thought should be given to situational factors, position power, task structure and leader-member relations when assuming a leadership position, for the administrator's style of leadership is not as important as the fit between that style and the situation in which the administrator must function. Admittedly, it may not be possible to administer a battery of tests to the faculty and/or the administrator, but often a careful assessment will give some clues about the probability of a fit. Then the leader and the faculty must decide the degree to which adjustments could be made.

Budget was a serious problem to all programs; and therefore, I would recommend that the feasibility study which provides data to support the initiation of a new Second Step program include a detailed three-to-five-year budget plan with projected costs and realistic potential sources of income.

Respondents expressed considerable concern about faculty. Again, preplanning could possibly help. The feasibility study should also include an assessment of potential sources of qualified faculty, including the availability of faculty with necessary clinical specialties and teaching experience, and an estimate of the salary scale and other fringe benefits required to attract such faculty. If salaries appear to be low, if the area is geographically remote, if other institutions are competing for the same pool of candidates, acknowledge that securing qualified faculty will be difficult and determine before students are admitted whether or not it will be possible to offer a program.

Someone must provide leadership and expertise in curriculum design and development. Hopefully, all of the faculty would be well grounded, but such is often not the case. Curriculum planning for a new program is intricate and requires expert knowledge. Either the administrator should be well prepared or a consultant should be readily and frequently available to assist the faculty. The administrator and one or more faculty members should be prepared to provide leadership in research. And finally, I recommend that the process of preparing for NLN accreditation begin with the feasibility study prior to program initiation. Every decision about program planning and development should be made with the criteria in mind.

Conclusions

In this study of Second Step leadership, a particular behavioral motivation did not differentiate between administrators of accredited and non-accredited programs. Similarly, neither the educational nor experiential preparation of the administrator was significantly related to the achievement of accreditation. Only on Task Structure, one of the measures of situational favorableness, were scores significantly higher among administrators whose programs had achieved NLN accreditation under their leadership.

The particular task given as the frame of reference for all respondents was that of producing the Self-Evaluation Study, as required for NLN accreditation. Thus, the distinguishing characteristics appear to be the clarity with which the goals, priorities and procedures of this complex administrative task were perceived and the amount of structure that they were therefore able to bring to it.

This talent for bringing order out of chaos emerged again in the interview data. All respondents experienced similar difficulties in launching their Second Step programs, but administrators of accredited programs discriminated more clearly between the most and the least problematic areas.

They demonstrated an ability to impose a certain sense of structure upon wide-ranging areas of administrative responsibility by taking more direct action, acting sooner, and by applying more different approaches to the solutions of problems.

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THREE MODELS OF SECOND STEP PROGRAMS: THE IDEAL VS. THE REAL

Marilyn Little

I remember my confusion when I first began working on research in nursing education. Like other lay persons, I assumed nursing education was one entity. All programs, I assumed, guided women and men--but mostly women--from the freshman novice stage to professional status through a combined clinical-classroom experience. It took some time to clarify for myself the labyrinth of nursing educational programs and to understand such terms as generic, Second Step, Two Plus Two, AD versus diploma, and professional versus technical. I finally thought I had it mastered when I could clearly see how different Second Step programs were from generic and how these new Second Step programs "articulated" with diploma and AD programs. Second Step programs which existed as an entity within nursing must obviously be quite similar in their philosophy, curriculum, teaching methods and student enrollment.

Then I participated in the data collection on the NSSP project. I visited six different Second Step programs and talked with faculty and administrators. I observed classes and met students. I read bulletins, catalogs and accreditation reports. I scanned reams of computer printouts pouring forth minutiae of data on students' attitudes, orientations, academic behaviors, career patterns and family life. As I absorbed these experiences and sifted through both qualitative and quantitative data, I discovered my early preconception was not correct. Second Step education is not a unified entity within nursing education. A wide variety of approaches exist within Second Step education; programs differ in philosophy, objectives, curriculum, faculty interaction and student responses. I began to shift my attention from attempts to describe a monolithic type of nursing education to an exploration of the varieties within this one form of nursing education. What were the differences among programs?

How were they similar? Could I find a framework within which to chart and describe these varied programs?

Last year I reported some rudimentary work I did on varieties of Second Step programs. I constructed three models of nursing education which described three different approaches to Second Step education. I called these models: Complementary, Collaborative and Critical. A model, as you know, is an abstract description; it portrays the components of a program and the way in which these components fit together into a meaningful whole. A model is not real; that is, it is not a description of any actual program; it is a theoretical abstraction, a scheme of the way things may fit together. In a way, it portrays an ideal type; it describes how the philosophy of the program, its objectives and curriculum would fit together if everything were ideally consistent.

Today, I would like to extend the ideas I presented last year. Using data from observations, interviews and surveys, I plan to do two things: first, I will describe the ideal model types. I will clarify the theoretical underpinnings of each model and the weltenschaaung or world view each model represents. Secondly, I will explain the theoretical assumptions each model makes on curriculum content, method of instruction and leadership. I will then describe ways in which real programs deviate from these models. Programs, like people, are not perfect; they cannot perform consistently around some ideal standard. When programs do not meet faculty-student expectations, tensions may arise. Program inconsistency, by itself, however, does not necessarily produce conflict. The amount of conflict generated depends upon the people affected and upon the areas in which the program does not follow its ideal.

A. A Theoretical Description of Three Models

1. Complementary Model

The first of the three models, the Complementary, is an older model of nursing education. The Complementary Model perceives nursing as an occupation assisting medicine in the delivery of health care. This model assumes a rather narrow role for nurses; nurses are responsible for procedures in patient care involving a minimum of judgment and skill. The occupation is carefully defined and practices within well-known legal and professional limits. When nurses go beyond these limits, they must do so indirectly and discreetly.

The weltanschaaung reflected by this model of nursing education may be as follows: The world is governed by a predetermined order, either a moral order or a biological order. The ordering of the universe is a given; relationships are arranged by a God-given decree or by some biological imperative. Authority is assumed and absolute; living a good life means finding one's place or niche in that predetermined order and fulfilling one's potential as given. Social order is maintained through evoking obedience to the natural order. Power is displayed through overt dominance. Because order is assumed and authority tends to be absolute, resistance may assume covert passive forms in which individuals loyally assume a given role but tacitly undermine the system and the people in authority.

2. Collaborative Model

The Collaborative Model also assumes that social relationships are primarily cooperative; this model focuses upon ways in which human beings assist each other in meeting goals of mutual importance. Objectives within this model stress adaptation rather than confrontation, cooperation rather than conflict, and collaboration rather than negotiation. The key assumption is that professional relationships are collaborative.

The Collaborative Model may rest upon either a humanistic or a rational orientation. The humanistic orientation focuses upon man as a spiritual being. Humanism may have either a religious or a secular base. It may be inspired by theological teachings on the spiritual nature of man, or it may reflect the cultural humanism as expressed by the human potential movement with its emphasis upon development of each human being.

Or, a program within a Collaborative Model may assume a rational rather than humanistic approach. Relationships between individuals, between individuals and institutions, and between institutions and society are rational and orderly. Systems theory may be applied to understand both our society and the position nursing occupies with the health care system.

3. Critical Model

The third model, the Critical Model, assumes that conflict, rather than cooperation, is the key to understanding social order. It assumes that resources are limited, rather than infinite, and that competition emerges over the control of these resources. When conflict theory is applied to the delivery of health care, it calls attention to the inequitable distribution of health care services and recognizes the political relationships among professional groups. It assumes a critical view of the impact of the health care system.

B. An Examination of Six Second Step Programs

1. Program Content: Curriculum

Programs constructed around those three different models would be quite different in curriculum content, instructional methods, and leadership. First, programs in these three models would vary in the spread of the curriculum, that is, what they consider the appropriate domain of nursing education. In the Complementary Model, nursing is defined rather narrowly to refer to patient care in a structured setting. Nursing exists as a discrete occupation and does not overlap much with other health care occupations. Nursing education, therefore, should focus on specific material related to nursing care with only minimal coverage of material from other disciplines, e.g., cross-cultural studies of health care systems or economics of health care systems. Furthermore, students would not be expected to cover this material elsewhere.

The Collaborative Model assumes nursing overlaps with other disciplines. Nurses must have some knowledge of these disciplines to work in a collaborative relationship with other professionals. Therefore, nursing education must expose the nursing student to a wide range of material; it should be a liberal education, incorporating content from the social sciences and humanities.

Like the Collaborative Model, the Critical Model assumes nursing coexists with other disciplines. However, since these disciplines may not always have similar interests and do not occupy similar positions within the health care system, nursing may not be able to work in collaborative relationships; at times nurses may be in conflict with other professionals, e.g., administrators, physicians, social workers. Nurses may also be in situations where the patients' interests conflict with the agency's. Therefore, nursing education should include not only a knowledge of concepts from other disciplines, but an evaluation and critique of that knowledge. Nursing education should include a critical appraisal of behavioral science theories and an awareness of how these various theories may affect the patient, the nurse and the health care system.

I found in my interviews with faculty and my examination of program documents that programs develop their curricula with the Collaborative Model in mind. Faculty are committed to liberal education. They feel nursing ideally belongs in the university, where students may broaden their horizons with coursework in other disciplines. This material may then be applied in a nursing curriculum. This is, by and large, the philosophy of virtually all Second Step programs.

Do nursing programs achieve this ideal of collaboration with other disciplines? How successful are they in the application of liberal arts material to nursing practice? On the basis of our data, the answers are rather disappointing. The actual placement of behavioral science material in Second Step programs differs greatly from the ideal.

In our interviews, nursing educators were asked where they thought each of the following types of materials should ideally be placed in the curriculum, given the following four choices:

Behavioral Science Materials

Theories of human development and growth
Theories of communication and leadership
Dynamics of family interaction
Cross-cultural studies of health care systems
Impact of environment on health
Social class and illness
Economics of health care systems

Choices for Placement

General Education courses
Required supporting courses from other departments
Nursing curriculum
Electives

On the average, faculty members interviewed felt that less than a third (30%) of this material should ideally be taught in nursing courses (Figure 1). Most often they thought such content should be covered by courses in other

FIGURE 1:

IDEAL PLACEMENT OF BEHAVIORAL SCIENCE MATERIAL:
FACULTY IN SIX SECOND STEP PROGRAMS
(N=26)

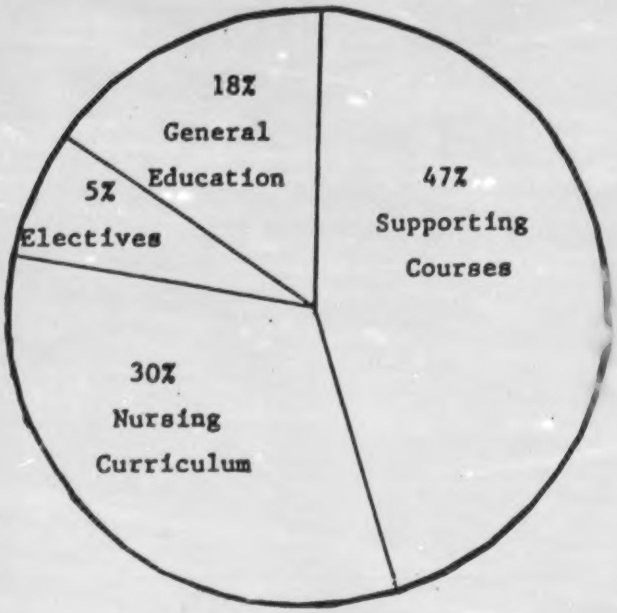
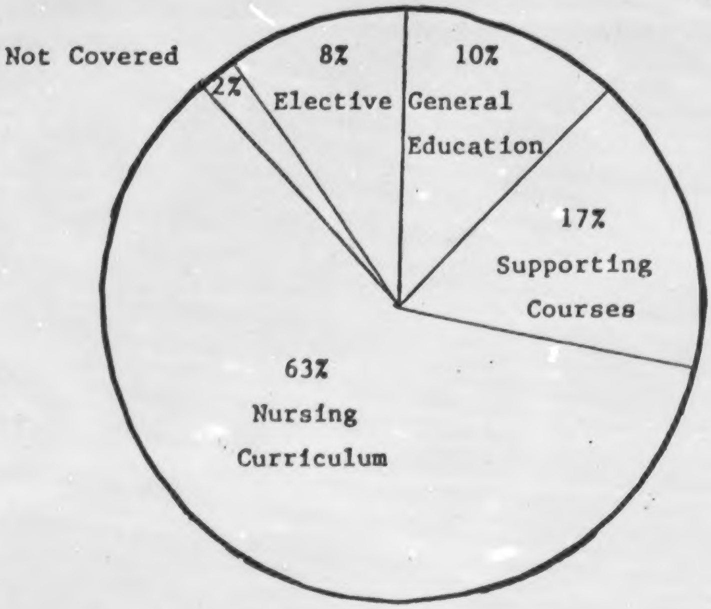


FIGURE 2:

ACTUAL PLACEMENT OF BEHAVIORAL SCIENCE MATERIAL:
FACULTY IN SIX SECOND STEP PROGRAMS
(N=26)



disciplines (47%). These courses may be required supporting courses, e.g., a course in ethnic studies, sociology of the family, or economics of health care. All Second Step students would be expected to take these courses in other departments of the university. There was relatively little expectation that behavioral science material should be covered through either general education courses or electives. Thus, the ideal curriculum would include behavioral science material acquired from other disciplines and then applied in the nursing curriculum.

Actually, however, this is not apparently the way it works in Second Step programs. When the same faculty were asked to indicate where this material was now actually covered in their curriculum, the picture was reversed. Almost two-thirds (63%) of the material is currently taught in nursing, and only 17% is covered by required supporting courses in other disciplines (Figure 2). GE and electives take care of less than one-fifth (18%), and 2% may not be covered any place. Thus, while the ideal is collaboration with other disciplines, the reality is nursing instructors assume responsibility for coverage of a wide variety of liberal arts material.

The actual coverage of behavioral science material may differ greatly from the ideal, but this rather large discrepancy between the real and ideal does not seem to bother nursing faculty. Most of the faculty I interviewed were quite satisfied with their curriculum. There were, however, a few faculty who voiced some concern. Some regretted the lack of exposure their students were receiving to other ways of thinking. One faculty person said:

> When nurses start reteaching other disciplines, it gets processed into nursing thinking instead of expanding out. It can be inbreeding and really limiting. Everything shouldn't be seen from a nursing perspective. I think the curriculum gets watered down.

But how does a course get "watered down"? By what process is material reduced to a lower level of conceptualization? Why does this occur? Let's take a hypothetical example. Let's suppose that you have a new Second Step program. You feel it is very important for baccalaureate nurses to understand the research process; you are convinced that one of the ways by which nursing can define itself as a profession is to articulate a body of knowledge, to take responsibility for generating knowledge. What better way to educate nurses to do this than to train them in the research process? You decide that since it is nursing research that you want to emphasize, you will teach the course within the nursing department rather than have the students take a research class in another discipline.

The first problem, of course, is to find a faculty person to teach this class. Fortunately, you have a bright, energetic new faculty member who just received her doctorate. She has an enthusiasm and appreciation for research but unfortunately her training and experience is limited to possibly two or three graduate courses and her doctoral research project. In setting up the course, she chooses materials and topics reflecting what she knows about research. She chooses a textbook on experimental methods because that's the method she learned. In preparing her lecture notes, she relies on authorities in the field because her own experience is limited. In the exams she asks students to recall the ideas presented in the book. She does not ask students to critique studies because she herself is somewhat confused about criteria for good research. Her course, therefore, tends to emphasize memorization and recall of material presented by "experts."

Let's suppose that you decide instead that it is really important to staff this course with a person who has had a great deal of training and experience in research. You are either lucky enough to have this person on your faculty or you decide to have your students take a research course offered by an experienced researcher in another department. This instructor may demand a great deal more of the students. She may ask students to compare three or four methods of research and develop an understanding of the strengths and weaknesses of each method. In the exams, this instructor may give the students a hypothetical situation and ask them to select the method most appropriate to the problem. They must defend the method they have chosen, tell why it is appropriate and discuss the problems they may anticipate in using that method. Unlike the first course which requires that students respond as novices in simple identification and recall exercises, this course expects students to analyze, compare, contrast and synthesize material, i.e., utilize critical thinking. This method of instruction, of course, more completely fulfills the Second Step program objective of developing critical thinking.

The important point I wish to make here is that students cannot be guided to expertise if the instructor herself is a novice. The expert can help students gain an overall view of the field, but the novice instructor who herself lacks that comprehensive gestalt is limited to the presentation of isolated and limited concepts. Having courses taught by persons with superficial knowledge of an area not only dilutes or waters down the content but does an injustice to the entire thought process underlying that area of knowledge.

It seems to me that departments of nursing are expecting a great deal from their faculty when they ask them to be responsible for so much material from such a variety of disciplines, e.g., psychology, sociology, anthropology, economics, as well as anatomy and physiology. Perhaps, the impact of these high expectations on both the faculty's well-being and student's learning experiences should be assessed.

2. Method of Instruction and Teacher-Student Roles

Let us now examine a second area of Second Step education--method of instruction and teacher-student roles. The Complementary Model emphasizes attainment of specific factual knowledge so that each student nurse will reach a level of minimal safe practice. Methods, therefore, reflect a concern with factual material. Objectives are phrased quite precisely, and evaluation favors the objective testing of true-false and multiple choice rather than the more subjective, comprehensive essay tests. The Model's adherence to authority influences the teacher-student relationship. The teacher uses more traditional methods to convey the material as she assumes responsiblity for the learning experience; the student is encouraged to follow a more passive, conforming role in the assimilation of that material and feeding it back through testing. Thus, the hallmarks of a Complementary Model program are specific, narrowly focused objectives, traditional means of presenting and evaluating material and a traditional teacher-student role with the teacher assuming primary responsibility for learning experiences.

In contrast, the Collaborative Model assumes nurses work in a team relationship with other professions. Thus, content overlaps with other disciplines; and expertise depends not only upon the attainment of specific skills but the development of leadership, managerial and communication skills; objectives are more open-ended. They tend to focus upon a process of development within the student, in which the student grows in confidence and leadership ability. Since the program emphasizes collaborative roles, the student is treated as an adult learner and a peer. He/she is expected to assume a more active role in establishing learning experiences. Thus, a Collaborative program may be less focused and more broad in its goals and objectives; instructors may assume a role of facilitator or resource person and direct the students in the completion of individual or group projects. Papers, class presentations and essay tests are appropriate tools for evaluation of the students' performance.

The Critical Model is similar to the Collaborative Model in its emphasis upon process. It, too, favors rather broadly defined objectives. However, it goes beyond the Collaborative Program because it stresses the critical evaluation of material. It, therefore, assumes students will not only attain a cognitive knowledge of theory but will critically evaluate that theory and its application to practice. Evaluation techniques, therefore, help the student demonstrate an ability to synthesize broad areas of knowledge and then integrate that material with his/her own philosophy and experiences. This kind of critical synthesis and integration requires highly developed cognitive skills of critical thinking, ability to deal with abstractions and cope with ambiguity. Students are evaluated primarily through individual projects which encourage them to combine the classroom theory with the clinical practice.

a. Teaching Styles

Faculty members at the six programs in this study favor a style appropriate for the Collaborative Model. When they were asked in interviews to state their preferences for teaching styles, most of them chose the Affirmative method, a style of teaching which is most appropriate for this model of education. Affirmative style emphasizes recognition of the students' background and experiences and student-teacher collaboration in the learning process. This mutual collaboration of student-teacher is aptly described by the following respondent:

> We guide them to help them get into their areas; and they also have to help identify areas; so it's kind of mutual collaborating. The nurse practitioner team has a colleague relationship with our students that really--it's almost like they've been accepted into the club. We feel that they've made the commitment to move in this direction, and we are assisting them in the final steps toward it. Then, once they've gone through the program and they're nurse practitioners, we are all colleagues pretty much on the same level.

Rationale for this choice of Affirmative style of instruction is based partly upon the recognition in Second Step programs that the students are mature, experienced learners. They have often had years of experience, and it is not appropriate to treat them as novices.

A second rationale is based upon instructors' philosophy of learning. Learning occurs only through activity and involvement; a student can't learn if she/he is passive. The teacher's responsibility then is to set the stage or provide opportunities for the student to learn:

> I'm convinced that these people have to be treated as adults, as mature, independent individuals. And they have to be responsible for their learning . . . Everybody has to be active. You can't learn and be passive. You can't just sit there and listen to me talk to you and learn very much that way. You have to participate actively. You have to be responsible for your own learning . . . I seldom lecture anymore. I open my classes by telling them it is a learning community . . . I see myself, my role, as a resource person to them--the explainer, the motivator, the counselor, the resource. If I don't have it, I'll get it for you, that kind of person.

The traditional style of instruction which may be appropriate for Complementary Model programs was seldom chosen by interviewees. The Traditional style of teaching focuses upon presentation of content through teacher-directed activities and lectures. When nursing educators chose this style, they always qualified their answer. They indicated they chose this approach only for certain classes in which specific content must be covered, e.g., Science Principles or Pathophysiology classes. Or, they indicated they chose this approach because students needed material to make up for deficits in their background. Students were not ready for the Affirmative style of instruction. They needed content which the instructors felt could be provided only through lectures and direct presentations. Thus, the Traditional style was recognized as legitimate in two types of situations--classes demanding presentations of heavy factual content and areas in which students had deficits of learning.

The Therapeutic mode of teaching which may be appropriate for either the Collaborative or Critical Model was seldom chosen by nursing educators. The Therapeutic method emphasizes role change; it focuses upon the students' needs as women and as nurses to gain knowledge coupled with assertiveness. This type of instructor wants to help students make the transition from their traditional roles to more effective, responsible professional roles. One instructor, for example, perceived this as part of her responsibility.

> There are relatively few that have a very clear vision of where they're going to go . . . There are people really struggling with where they want to go, and they need help with that.

b. Structuring the Learning Experience

Classroom observations, course outlines and faculty-student responses to survey items suggest, however, that the Affirmative mode of teaching may be an ideal which is rather difficult to achieve. With Affirmative teaching in the Collaborative Model, the student assumes some responsibility for creating learning experiences. Students participate in formulating objectives and projects to meet those objectives.

Classroom observations plus examination of course outlines suggest that Traditional instruction still has a place in Second Step programs. In many classes, instructors assume total responsibility for structuring the class. Objectives, presentation and evaluation are all very tightly controlled. Material is highly organized and cut up into bite-size pieces and spoon-fed to students through handouts and lectures. Students are expected to take copious notes and dutifully feed back that material on examinations.

These observations were further substantiated by faculty-student responses to some items on the Nursing School Environmental Inventory. On one scale, entitled Clear, Concise Encapsulated Learning, both students and faculty indicated their learning environment was very structured. Compared with generic students, students in Second Step programs scored over two standard deviations above the norm on this scale; faculty scored even higher: three standard deviations above the mean.

Our findings on method of instruction and teacher-student role suggest a paradox, similar to that found in the area of curriculum and content. Instructors in Second Step programs favor a teaching style which fulfills the goals and expectations of a Collaborative Model type of education. However, they may have some difficulty implementing that style. While great variation exists among programs, instructors and specific courses, many courses do reflect a fairly traditional style of organizing material with tight control over course objectives, presentation and evaluation of material. When this occurs in a program, students complain bitterly about the disparity between program philosophy and method of instruction. They complain about program rigidity, not being treated as adult learners, and too much busy work.

3. Leadership Styles

Just as the three models of nursing education vary in curriculum content and methods of instruction, they vary in ideal leadership styles. The Complementary Model accepts the control of a hierarchy and relies upon the strong leadership of an individual or small group of people. The Collaborative Model perceives leadership as a shared process; it strives to establish a system in which all faculty and administrative personnel can contribute to decision-making. Group process is important in the Collaborative Model. Within the third model--Critical Model--conflict and negotiation may be assumed as part of the governing process. Groups within the faculty may recognize their different interests and may be more willing to articulate their disagreements. In the Critical Model, resolution of conflict may be a more open process than in either the Complementary or Collaborative Models.

In the six programs we studied, faculty generally favor democratic processes and are most committed to resolving issues through group action. For some programs, this democratic process was crucial to their development; faculty who have been with these programs since their inception believe it was this commitment to the group which enabled their programs to pass successfully through the early difficult years. For example, accreditation was a big hurdle. Only as everyone on the faculty pitched in and worked together were they able to accomplish their goal. There is, therefore, among these six programs, a widespread belief in and acceptance of democratic processes and group leadership.

Some faculty noted, however, that while there was an ideological commitment to democratic process, the usual types of power hierarchies and networks existed in their departments:

> I think that on one level it is very democratic. And yet, there really is a kind of hidden hierarchy that you don't really get into until you've been here awhile. Then I think it is really very strong, and you find some of the people who have been here for quite awhile have strong control.

Individuals may exercise strong control; but if the ideological or public commitment is to democratic process, this power must be either covert or limited in its scope to be acceptable. When power is exercised covertly, democratic processes may be subverted in a number of ways. For example, the faculty may discuss an issue and vote in favor of a change. They may add a new course or a workshop for faculty. But nothing ever happens; the faculty's vote is never implemented by action. In any bureaucratic institution, changes require taking action within a time framework.

There are deadlines for filing papers initiating a new course, for example. By simply not doing anything, a person in power within the department can prevent an event from occurring. She does not move against the faculty decision; she simply does nothing. Control is maintained through passive subversion of group aims.

Covert exercise of power also occurs when persons in power emotionally manipulate resisting individuals into conformity. An individual may have a viewpoint which differs quite radically from that held by the leader. Opposition may be handled by sidestepping issues and focusing upon personalities. For example, the leader may imply that anyone holding such a point of view is negative, not really committed, or not good in some way--not a good teacher, or not a good role model for the students. As the argument moves away from cognitive issues and hints at personal issues, dissenters become uncomfortable. They may feel vaguely guilty. Because they want to be part of the group and not outsiders, they concede.

Power, of course, need not be subtle; it may be overt and authoritarian. But because of the commitment to an egalitarian mode of governance, authoritarian power must be limited in its scope to be acceptable. Faculty may, for example, acknowledge that department control is authoritarian; but they maintain it is okay because it is exercised within certain limitations. Leaders in nursing departments have a choice of domains in which they exercise power. These include teaching methods and materials, curriculum content, department procedures, campus politics, federally funded grant programs and community relationships. Some of these domains are far removed from classroom teaching; faculty may consent to authoritarian leadership in a domain which does not interfere with classroom teaching. As leadership extends its control into curriculum and teaching issues, faculty are more likely to become concerned and resistant.

In those situations where power operates more covertly, both leadership and faculty response tend to be passive in nature. The passivity of leadership and response contributes to a strain in relationships, because leaders and faculty tend to avoid rather than confront. In the second type where power is more overt, the tensions vary according to the position the faculty member occupies within the department and the leaders' choice of domain of control. Thus, some faculty may be very content with an authoritarian leader who handles all those decisions in areas far removed from and having little impact upon them. Other faculty may feel more tension if they work more directly with the leader in domains she has selected for control.

In spite of ideology supporting egalitarian governance, Second Step programs operate with power structures which vary in visibility and impact. Whether or not an individual faculty member perceives this control as intrusive depends upon the leader's chosen domains of control and style of leadership plus the faculty person's position within the department.

C. CONCLUSION

In summary, I believe that the Collaborative Model is accepted as the appropriate ideal model for Second Step education today, and perhaps even for other types of nursing education. Nursing educators are committed to a weltanschaaung which emphasizes cooperation and collaboration among professionals. Whether they phrase it in terms of systems theory or in the humanistic vocabulary of self actualization, they see the need for nurses to work together with other professionals within the health care system. They believe that their students are peers and mature learners who can and should assume an active role in the learning process. They are committed to a kind of communalism in which each person contributes to the group effort. Hierarchies and absolute control invested in a strong leader are not popular forms of leadership.

Our findings suggest, however, that as with all human enterprises, progress is uneven. Programs have not developed evenly. For example, a program may resemble the ideal Collaborative type in every aspect except structure of classroom learning. In this respect, the program may be struggling with too rigid objectives and with tight control of content and methods by instructors. This defies the philosophical commitment to treating the student as an adult learner. In another program, classroom instruction may follow the lines suggested by the Collaborative Model, but the leadership exerted by the administration may be autocratic and not the least bit democratic or sharing in responsibility.

Perhaps the two most important elements are trust and control: Can nursing educators trust their colleagues in other disciplines to teach material which will be useful in developing their students' ability to think and grow intellectually? Can the faculty trust that students may be able to make application of that material to the nursing process? Can instructors trust students to set up learning experiences? Can they trust students will follow through on their responsibilities? Can a faculty be expected to make wise decisions in its own governance?

Control emerges when there is a lack of trust. When nursing instructors do not trust students to assume responsibility, they control the learning process. When a department chair does not trust her faculty, she intervenes either directly or indirectly and makes those decisions herself.

The real problem may not be that programs are inconsistent in some phases of their curriculum or interaction. Programs, like people, are never perfect. What may be most troublesome is not a deviation from some ideological norm. Rather what some faculty and students in Second Step programs are troubled by is the lack of trust, which is translated into a need for control. Quite possibly they would agree with this faculty member who responded thus when I asked her what changes she would like to see in the interaction within her department:

> I'd like to see it changed. I have hoped that would happen as we get to know each other. I hope we can trust each other.

BECOMING PROFESSIONAL

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Factors Affecting the RN's Decision to Enter a Second Step Programme

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Characteristics of Novice and Expert Performance: Implications for Teaching the Experienced Nurse

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FACTORS AFFECTING THE RN'S DECISION TO ENTER A SECOND STEP PROGRAMME

Marilyn F. Jackson

This paper reports a three-year study to determine the factors that encourage or hinder registered nurses' continuation of their nursing education at a university school of nursing. The study involved 106 students enrolled in their first term of a two-year post-diploma baccalaureate nursing degree programme at the University of Victoria, Victoria, British Columbia. The study also examined the demographic characteristics of the students: age, marital status, type of diploma nursing education, year of graduation from a diploma nursing school, number of years employed as a registered nurse, and nursing position held prior to entering the university programme.

Building a curriculum for a post-diploma baccalaureate nursing degree programme requires decisions about the content and processes to be incorporated into the programme. Through increased knowledge about the registered nurses who enroll in these programmes, we, as nurse educators, will be able to design, implement and evaluate a curriculum that is relevant to the learning needs of the student.

Literature Review

A review of the literature revealed that no Canadian studies of registered nurses enrolled in post-basic nursing degree programmes had been published, though the programmes themselves, their curricula, and assessment techniques for validating prospective students' knowledge and level of nursing competencies had been reported (Moore, 1976; Parker and Wain, 1977). The British and American nursing literature also contains few studies on factors that motivate or inhibit a registered nurse's entrance into a university nursing programme. Hillsmith (1978), in her study of nursing students enrolled in the University of Bridgeport, stated that motivating factors identified by students were increased job satisfaction, improved job opportunities, increased professional competence, job security and desired change in position. Obstacles these students identified were challenge examinations, financial and family strains, and the rigidity of the curriculum. Zorn (1980), reporting on demographic characteristics of registered nurses then enrolled at Youngstown State University, stated that the majority were female, married, diploma nursing school graduates working in a hospital setting, and with an average age of 32.7 years.

Other studies reviewed the processes that students were expected to complete while enrolled, student and faculty perceptions of specific post-diploma programmes, and behavior patterns of registered nurses enrolled in such programmes (Wooley, 1978; Balogh et al., 1980; Wilson and Levy, 1978; Muzio and Ohashi, 1979; Raderman and Allen, 1974; Shane, 1980).

There is also a shortage of reported studies related to women in other professional and para-professional groups who continue their education beyond the basic requirements for entrance into their respective professions. Durchholz and O'Connor (1975) reported that the two major reasons for returning to university given by those women they studied were preparation for employment and fulfillment of a need for educational achievement. Farmer (1976) found that married women who return to university to study were highly motivated and had less fear of success than other women in their respective fields.

Studies as to why mature students enroll in continuing education programmes related their participation to multi-motivational factors including a need for stimulation, social welfare, social contact, professional advancement, cognitive interest, and external expectations (Boshier, 1977; Boshier and Riddel, 1978; Morstain and Smart, 1974; Johnstone and Rivera, 1965). O'Connor (1979) reported similar findings in her study of registered nurses enrolled in 24 continuing education programmes at American universities.

For this investigator, the most significant result of the literature review was that so few studies examined the motivation of registered nurses for further university level education during this period of tremendous change in health care technology and delivery services, of increasing costs for those services, and increasing demand for highly qualified skilled professional nurses.

Definition of Terms

Diploma programme: Programmes approved by the provincial approval body for nursing education for the preparation of graduate nurses who are eligible to write the Canadian Nurses Association Testing Service Examinations or its equivalent.

Post-diploma/post-basic Baccalaureate programmes: Programmes presented in a university school of nursing for registered nurses and leading to a baccalaureate degree in nursing.

Motivational factors: Those elements identified by registered nurses that encouraged their enrollment in a university nursing baccalaureate degree programme.

Design and Methodology

A questionnaire was developed with thirty-two items related to motivational factors, six items related to psychological support systems, nine items related to financial support systems, and twenty-one items related to possible barriers to enrollment. Each student was asked to rate each identified factor on a 6-point Likert-type scale with zero indicating the factor to be of no importance and five indicating the factor to be very important. This allowed for a study of the importance of each factor and provided the overall frequency distribution.

Other questions collected pertinent demographic information as to age, marital status, type of diploma nursing education, number of years employed as a registered nurse, and position held prior to entering the University of Victoria nursing programme.

The University of Victoria School of Nursing admitted its first class of students in 1976. The questionnaire was completed by 106 out of a total of 135 first-term students enrolled during November and December of the years 1977, 1978 and 1979. Students participated voluntarily and could not be individually identified.

To determine its reliability, a test-retest analysis of the questionnaire was completed prior to its first administration. Using a Spearman-Brown formula, the reliability coefficient for the questionnaire was $r_{xx} = 0.91$.

Limitations to the validity of the study include its reliance upon retrospective data based on the participant's recall and self-reporting of the situation, the participant's possible desire to choose or weigh a factor according to how the respondent perceived the professional correctness of the answer, and any recently encountered obstacle or motivating factor which may have influenced the student's responses. A possible selection bias may have existed as participation in the study was voluntary. Finally, the study was restricted to the students enrolled in the University of Victoria School of Nursing.

Data Analysis

Respondents were divided into subgroups according to age range, marital status, type of diploma nursing education, range of years the subject had worked as a registered nurse, type of diploma nursing education, and position held prior to entering the University of Victoria nursing programme.

Frequency scores were calculated for the demographic characteristics of the participants and for each dependent variable. Cross tabulations between the subgroups and the total group were completed, using the chi-square statistic and the $< .05$ level of significance. The relationship between the level of importance of each motivational factor and each demographic variable was tested using a one-way analysis of variance, the level of significance again set at five percent.

Findings

Demographic characteristics for this sample are similar to those of the populations studied by Zorn and Hillsmith (Zorn, 1980; Hillsmith, 1978). As shown in Table 1, the age range in our sample was from 22 to 50 years, the largest group being between 26 and 30. The mean age was 28.5 years. The largest group of respondents (41%) were married, although seven students did not furnish data on their marital status.

Table 1. Age and Marital Status of Respondents

Age Groups	(N respond = 106) %	Marital Status	(N respond = 99) %
22-25	20	Single	36
26-30	28	Married	41
31-35	25	Divorced	18
36-40	13	Widowed	2
41-45	11	Common-Law (written in)	2
46-50	3		

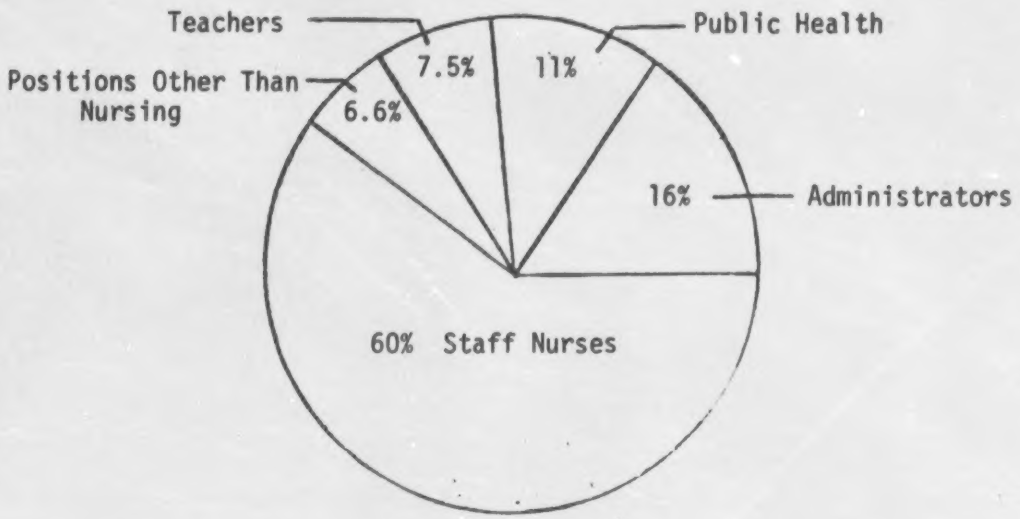
About eight out of ten (78.3%) students were graduates of three-year hospital programmes. As the diploma nursing programmes on Vancouver Island were situated until September, 1980, in the two hospital programmes in Victoria, and since one of the largest diploma programmes in British Columbia is the three-year programme at the Vancouver General Hospital, Vancouver, this high proportion of hospital-trained graduates is not surprising. As the number of community college graduates increases, it is expected that the percentage of graduates from these programmes in post-basic baccalaureate nursing programmes will increase proportionately.

Most (63%) of the students had graduated from their basic programme within ten years of entering the university. Three-quarters (75%) had worked as registered nurses between two and seven years, 40% having worked five years or less. Figure 1 represents the breakdown of positions held prior to entering the programme.

Motivational Factors

Table 2 presents motivational factors chosen by the students, rank ordered according to frequency of choice and level of importance.

FIGURE 1. POSITIONS HELD PRIOR TO ENTERING THE PROGRAMME



The desire to increase the level of nursing knowledge ranked highest both in frequency of choice and level of importance for all students. Although the rank order of factors changed slightly, the seven most frequently chosen factors were also the most important factors for the total group, importance being determined by the factor having a score of 3 or higher.

TABLE 2. Motivational Factors Chosen by Students

Motivational Factors	Frequency of Choice		Level of Importance	
(Ordered by frequency of choice and level of importance)	Number	%	Total Points	Mean
To increase my nursing knowledge	89	86	418	4.0
To obtain a future promotion	68	65	316	3.0
To give better nursing care	62	60	316	3.0
To obtain a degree in two years	57	55	282	2.6
To work in the field of public health	57	55	280	2.6
To be more effective in my present position	57	53	273	2.5
To avoid working shifts	55	53	271	2.5

Cross tabulations between the demographic subgroups and the motivational factors showed the following significant (.05) associations. Students who were aged 30 or less ($x^2 = 41.1$; df = 25), and students who were staff nurses (x^2 = 57.5; df = 25) more frequently chose factors related to the avoidance of working shifts and week-ends than any other groups. Students who had worked five years or less as registered nurses (x^2 = 35.2; df = 25) were more likely to want to work in the field of public health than the more experienced nurses. Although the majority of the younger nurses were also staff nurses, not all staff nurses were in the younger age group; therefore, these groups had to be considered separately.

Students in nursing positions other than that of staff nurse prior to entering the programme indicated a desire to be more effective in their present position (x^2 = 41.7; df = 25). The majority of staff nurses did not indicate that to be more effective in their present position was an important motivating factor. Teachers and nurses in public health indicated a strong concern for job security (x^2 = 46.3; df = 25). Teachers also identified the desire to enter graduate studies to be an important motivator.

The marital status of the student, the type of diploma education received, or the class in which the student was enrolled were not significantly associated with motivational factors.

Other interesting findings were that 75% of the students indicated that financial reasons were not a factor in returning to school, although 37.5% hoped to increase their present salary following graduation. Fifty percent of the students felt the need for mental stimulation was one factor that encouraged them in their decision; 37.5% of the students gave a high level of importance to the possibility that a baccalaureate degree might enable them to obtain a position outside of nursing while 18% viewed the degree as a means to enter another professional field such as medicine.

The one-way analysis of variance produced three statistically significant (.05) outcomes.* Respondents aged 30 or younger who had worked between two and ten years were more likely than the older, more experienced nurses to want to avoid working weekends (F = 4.575) and to want to avoid working shifts (F = 4.043). One other subsample was also motivated by a desire to avoid shift-work--those who had been previously employed as staff nurses rather than in administrative and public health positions (F = 9.49). As public health nurses rarely work shifts, this may be one reasons for the strong desire of the younger, staff nurse to work in the field of public health. No other significant differences between and within groups were determined.

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*In all cases, the degrees of freedom = 103.

Support Systems

The most significant finding in relation to psychological support systems was the reported lack of support demonstrated by other registered nurses for the student's decision to enter the baccalaureate nursing degree programme. Only some students who had held teaching positions and some of the students over forty years of age identified any support from their peer work group for their decisions to continue their nursing education at the university. Families and friends were the important support groups for the majority of the students.

The main sources of financial support were students' own savings and some assistance from husbands. Though many of the students have verbally expressed concern about the lack of bursaries, student loans, or opportunities to work while enrolled, these sources were not identified as having any level of importance, perhaps due to the influence of certain extraneous circumstances. Students who participated in the study in 1977 and 1978 received a monthly government stipend, available to all nursing students in British Columbia. This stipend was discontinued in 1979.

Barriers to Enrollment

Three major concerns were identified: 1) insufficient funds were a major obstacle for all students, 2) married students identified more problems than any other group, and 3) as the age and work experience of the registered nurse increased, the number of barriers to be overcome also increased. For married students, the need to contribute financially to the family, to obtain necessary funds for child care, and to find reasonably priced housing were major concerns.

Teachers and the older more experienced staff nurses identified the lack of credit for evening courses in nursing as a major obstacle. As this study was of students who had overcome these barriers, the lack of part-time studies in nursing may have effectively prevented some nurses, who could not attend university full time because of geographic location or family responsibilities, from obtaining a baccalaureate degree in nursing. The older students were also concerned that work in their chosen fields of nursing might be unavailable to them following graduation.

Discussion of the Findings

M. Knowles (1970) incorporated Maslow's Need Theory (1970), that basic needs are antecedents to behaviors, into his model of motivation related to the adult learner. Knowles states that the adult learner is influenced by cultural forces as well as by the abilities, goals, values, attitudes, and interests of the individual. For Knowles, the higher level of needs that motivate the adult learner are the need to protect one's self image and self respect; to have new experiences; and to gain affection, recognition, respect, and admiration.

Nurses who enrolled in the University of Victoria School of Nursing indicated that a mixture of both personal and professional factors encouraged their decisions to continue their education. Students who participated in this study did not identify the need for money, the need for basic survival skills as motivating factors. By meeting the academic standards required for admission into the programme, they had already demonstrated to themselves and others an ability to achieve academically. By entering a university programme, by identifying the need to further increase their knowledge of nursing, these students indicated that they viewed a university education as one essential means of achieving their professional and personal goals.

These students were also individuals who were able to return to university independent of any perceived support from their nursing peers. It may be that when several factors begin to affect the students' ability to achieve the higher levels of need satisfaction related to self-esteem, recognition and respect within the nursing profession, they are motivated sufficiently to overcome any obstacles to continuing their nursing education in a university programme. However, further studies are needed in this area.

Implications

1. This study indicated the major motivational factor affecting a student's decision to return to university is related to a professional need to increase her knowledge of nursing. For faculty involved in planning and implementing the curricula for post-diploma university nursing programmes, an ongoing assessment of how students define "nursing knowledge" may assist in decreasing conflict between what faculty and students perceive as relevant curricular content and processes.

This does not mean that a curriculum is designed according to students' expectations. It does, however, infer that a curricular plan ought to attempt to meet the needs of both students and society, the first articulated by the students and the second reflected by the faculty.

2. Faculty when planning teaching methodologies and assignments need to be aware of the problems of the students, especially when the majority of the students are married. For example, learning to work in groups and to analyze the group process is an important leadership skill. However, if a student has to work in several groups in different courses at the same time, necessitating group meetings outside of regular classroom hours in addition to other reading assignments, conflict for the student may arise between the role demands of being a spouse and parent, and those of being a group member. Students may perceive the curriculum not as a means to increase their knowledge and skills in nursing, but as a test of how well they can cope with stress and anxiety caused by competing demands of home and school.

3. As insufficient funds were identified as a major obstacle for many students and as fees and other student costs continue to escalate, more studies are needed on the actual costs for these mature students, on accessibility for registered nurses to student loans and bursaries, and on providing access to university nursing programmes through distance-learning packaging of courses.

4. The role of baccalaureate education for nurses needs to be addressed. The fact that the majority of students who were recent graduates of diploma programmes did not perceive any support from their nursing peers for their decision to continue their nursing education at the baccalaureate level indicates a need for community colleges, other diploma nursing programmes, university schools of nursing, and professional nursing organizations to more clearly identify the advantages and role of baccalaureate education in the nursing profession.

5. As the study indicated, motivational factors and problems vary as widely as do the demographic characteristics and experiences of the students. Faculty need to be aware of the special concerns and motivations of each group in their counselling and assisting of students.

6. An examination of the motivational factors of students presently enrolled in university nursing programmes may provide some guidelines for the promotion of increased participation in and support for these programmes by registered nurses in the community.

7. Students tend not to be motivated by any need to be more effective as nurses. These and other findings present a challenge to faculty to design their courses in a manner that will motivate students to increase their knowledge about nursing, and to make the curriculum live for those students who view the nursing degree as a means to obtaining a position outside of nursing, or to entering another professional field such as medicine.

8. Finally, this study indicates a need for evaluators to consider motivational orientations when evaluating a curriculum. If the reasons for returning to university vary, if the obstacles that have been overcome arise again, if the support system changes, the impact of the programme on

the student will vary, independent of the course content and/or the instructional mode.

Summary

This study examined over a three-year period the motivational factors, support systems, and barriers that affected students' decisions to enroll in the University of Victoria School of Nursing. An analysis of the data indicated that although there were some significant differences between the various categories of students, the most frequently identified and important motivational factors for the students related to a professional need to increase one's knowledge of nursing and to changing one's position and conditions of work. Implications for nurse educators in designing, implementing, and evaluating curricula and for the nursing profession in promoting baccalaureate education for nurses were identified.

By increasing our knowledge about the registered nurses enrolled in post-diploma baccalaureate degree programmes, we, as nurse educators, can more effectively design curricula that will assist students in reaching their individual professional and personal goals.

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PROFESSIONALIZATION OF NURSING STUDENTS IN SECOND STEP PROGRAMS

Deborah Glass and C. Julie Esch

For some years now, the field of nursing has been in a transitional stage, changing from an occupation to a profession. The establishment of Second Step nursing programs is a vital part of this change. A concern among nursing educators has been the manner in which students are socialized into the profession. This paper will explore the institutional and student characteristics of the socialization process that lead to the development of a professional identity. Specifically, our focus will be on the socialization of nurses who graduated from Second Step programs between 1975 and 1980.

> Ratified by more than two generations of use in psychology and sociology, the technical term socialization designates processes by which people selectively acquire the values and attitudes, the interests, skills and knowledge--in short, the culture--current in the group of which they are, or seek to become, a member. It refers to the learning of social roles. (Merton, 1957, p. 287)

Institutional and student characteristics that determine a student's successful acquisition of professional behaviors and attitudes were delineated in much of the socialization literature we reviewed (Sibley, 1963; Rosen and Bates, 1976; Sherlock and Morris, 1967; Brim and Wheeler, 1966; Merton, 1957).

The work of two sociologists, Basil Sherlock and Richard Morris, succinctly covered the major socialization factors. They also combined these factors into a paradigm which enables the testing of hypotheses about socialization processes. From their study of dental students, these investigators developed a model that they believed could explain the socialization processes that students experience. In their paper on "The Evolution of the Professional" (1967), they suggest that their model can (1) identify factors that tend to encourage or inhibit the acquisition of a professional role, and (2) measure the frequency, strength and type of professionalization of a specific population.

As diagrammed in Figure 1, this three-part model proposes that professional outcomes result from the recruitment of students by an institution and from socialization processes that students experience while enrolled

RECRUITMENT

- Background Characteristics
  - -occupational geneology
  - -occupational status
  - -occupational situs
  - -source of income
  - -exposure to the occupation
  - -social origins
- Entry Perspectives
  - -intrinsic/extrinsic motivation
  - -occupational reward preference
  - -expectancy of access
  - -career commitment

SOCIALIZATION PROCESSES

- Institutional Processes
  - -selection
  - -sequestration
  - -didactic instruction
  - -apprenticeship instruction
  - -sanctioning
  - -certification
  - -sponsorship
- Student Organization and Subculture
  - -studentship
  - -apprenticeship

PROFESSIONAL OUTCOMES

- Knowledge
- Technique
- Ethics
  - -standards of excellence
  - -universal standards
  - -altruism
  - -service and sacrifice
  - -protection of client
  - -protection of colleague
  - -policing of ethics
- Professional Culture
  - -jargon
  - -heritage
  - -etiquette
  - -marketplace information
  - -career plans

Figure 1. The Sherlock & Morris Model

The first part, recruitment of students, is broken down into two subcategories: background characteristics and entry perspectives.

Variables related to background characteristics are: occupational geneology, i.e., family history of occupations/professions; occupational status, or rank; occupational situs, or location; source of income; exposure to the occupation; and social origins. Thus, the authors stress the need for information regarding the occupational history of students and their relatives. With this information, the extent of the family's influence on the student as well as the student's awareness of career options and amount of occupational and status inheritance can be determined. Predictions about career choice and reactions to socialization can be based, in part, upon whether the student came from a high to a low socioeconomic status background; from a health, commerce, academic, or service background; and/or from a family with few or many self-employed members.

Variables denoting entry perspectives are: intrinsic-extrinsic motivation which refers to a student obtaining personal satisfaction as well as economic rewards from a profession; occupational reward preference which refers to the overall reward that can be obtained from a particular profession in comparison to others; expectancy of access which refers to the student's assessment of the probability of being able to enter a particular profession; and career commitment which refers to an individual's sense of involvement in a chosen career.

The second part, socialization processes experienced while enrolled, is broken down into two subcategories; institutional processes and student organization and subculture. Institutional processes include the following seven variables. Selection refers to the balancing that occurs between the purposeful recruitment of qualified students and the subsequent attrition of some of those students. Sequestration refers to removing factors that might prevent a student from learning a professional role. Didactic instruction is simply the acquisition of knowledge and skills through course work, field studies, seminars, etc. Apprenticeship instruction, particularly significant in the adoption of a professional role, is where the student learns to integrate and apply the knowledge and skills obtained through didactic instruction with managed supervision. Sanctioning refers to rewards and punishments exercised through institutional authority, such as grades or admission and dismissal procedures. Certification refers to legitimizing the student's education through graduation and/or professional licensing. The last variable, sponsorship, refers to assisting students in the beginning of their careers.

The other subcategory of the socialization processes, student organization and subculture, is made up of only two variables. The first, studentship, consists of the ways in which students develop a sense of solidarity with one another. The second variable is apprenticeship which refers to working directly in the area for which one has trained, but still under the supervision of more experienced members of the profession.

The third part of the model, professional outcomes, contains the subcategories of knowledge, technique, ethics, and professional culture. The latter two contain several components. Variables for ethics are standards of excellence, universal standards, altruism, service and sacrifice, protection of client, protection of colleague, and policing of ethics. Components of professional culture are jargon, heritage, etiquette, marketplace information, and career plans.

To reiterate: the model developed by Sherlock and Morris suggests that professional outcomes result from the recruitment of students by an institution and from socialization processes students experience while enrolled. These three parts were interrelated with a number of variables categorized in each part. First, a number of student characteristics determine the degree to which an individual is successfully socialized. Second, institutions differ in functional and structural characteristics and, hence, in their ability to successfully socialize students into a profession. Third, degrees of interaction occurring between these institutional and student characteristics will determine the degree of student socialization, i.e., the acquisition of a professional identity.

Our research question, based on our review of the literature and specifically on Sherlock and Morris' paradigm, was: Can we predict degrees of socialization outcomes that lead to a professional identity?

Methodology

The sample for this investigation consists of the 185 female students from all six NSSP schools who completed four NSSP questionnaires: the Entry Questionnaire, administered at entry to the program; the First Year Survey and the Nursing School Environment Inventory, both administered at the end of the first year in the program; and the Graduation Survey, administered upon graduation from the program. NSSP staff duplicated a card data deck that was forwarded to the researchers along with the necessary code books for the four instruments.

Every variable from each questionnaire was sorted and assigned to one of the categories of the Sherlock and Morris paradigm. Variables from the Entry Questionnaire, First Year Survey, or Nursing School Environment Inventory were listed under the recruitment or socialization categories. Professional outcome variables were taken from the Graduation Survey. Once all the variables were assigned to categories, each category was checked to see that (1) each variable included was theoretically appropriate to that category; and (2) no variable was duplicated or repeated within or between categories. If two or more variables were similar in content, only one variable would be kept and the others excluded.

Every attempt was made to be consistent in the manner in which variables were excluded. Variables that provided behavioral data were given priority over attitudinal variables. (For example, "How many hours did you spend studying?" provides behavioral data, whereas, "How do you feel about studying?" provides attitudinal data.) If both items were approximately equal in this regard, the one that appeared earlier in the questionnaire was used. In this manner, the variables were reduced to a more manageable number for analysis.

Each category of Sherlock and Morris' paradigm now had at least one theoretically appropriate variable with these exceptions: "occupational situs" (recruitment); "selection" (socialization); and "universal standards," "protection of the client," "policing the ethic," "jargon," "heritage," and "marketplace information" (professional outcomes).

Based on the paradigm, we developed several questions and hypotheses that could be addressed by using the variables selected to represent its various components. We had hoped to test these hypotheses, and hence Sherlock and Morris' paradigm, by setting up a recursive structural equation model that would allow us to predict socialization outcomes based on student and institutional characteristics. Multiple regression using ordinary least squares procedures would have been used as the base for analysis. Due to the number of variables involved, however, the equations that were developed were complicated and cumbersome. Since variables had previously been grouped into the paradigm categories according to the theoretical rationale, it was decided that factor analysis might reduce the number of variables so that our equations could be more manageable.

The factor analysis was run but did not list the number of factors per category that were anticipated. However, those factors where variables were heavily weighted were used to create new variables. These new variables were used in three equations that had been developed to test three of the hypotheses. The regression analysis showed that our results from running the equations were statistically insignificant, and that our models were explaining very little. Because it was felt that the variables used from the factor analysis could have thrown off our results, four new equations were developed and run without the new variables. The first equation was uncomplicated and set up so that its results should be obvious--based on what the literature as well as our "common sense" said we should find; the other three equations were increasingly more complicated than the first. Unfortunately, the results of these four equations were also statistically insignificant.

It was tentatively decided that the researchers must have erred in the development of the structural equation models and not that the paradigm was wrong. Further testing needed to be done. Consequently, it was decided to cross-tabulate some of the independent variables--

student and institutional characteristics--with several dependent variables--professional outcomes. Although the use of structural equation models and multiple regression would have been more technically sophisticated, an analysis of these cross-tabulations, set up according to the theoretical rationale of Sherlock and Morris' paradigm, should give at least some indication as to whether or not we could predict socialization outcomes based on student and institutional characteristics.

Three outcome variables were selected that we felt would vary with the independent variables. These were:

How much of a personal stake do you feel that you have in your identity as a professional nurse?

_____ 1. Not much; I work as a nurse when I'm employed to do so, but I have no particular feelings about being a member of the nursing profession.
_____ 2. Only moderate; I think of myself as a nurse when I'm on the job, but it's not an identity I carry with me into other aspects of my life.
_____ 3. Undecided; I go back and forth between "2" and "4".
_____ 4. Considerable; a nursing career is important to me at present, although I may decide later to move away from this field.
_____ 5. Very great; I like to think of myself as a member of the nursing profession; and maintaining that identity is very important to me.

People differ in the importance they attach to different areas of life. For some people, for example, an occupation becomes the central aspect of life, a major focus for their energies and a major source of gratifications. For other people, major focus may be given to being a parent, participation in community or national affairs, involvement in the world of art or music, etc.

When you think of your life after college, how important do you expect each of the following areas will be to you?

	Not Important 1	2	Somewhat Important 3	4	Very Important 5
Career or occupation	_____	_____	_____	_____	_____
Marriage or continuing living relationship	_____	_____	_____	_____	_____

All three items were from the Graduation Survey and provided outcome variables according to the Sherlock and Morris paradigm. We felt that if a respondent were well socialized into the profession of nursing, she would have a great personal stake in her identity as a nurse. Not only does that make sense according to the socialization literature and the paradigm, but "common sense" seems to support it.

Someone who puts a great deal of time, effort, and money into becoming more professional should have a greater stake in her identity than someone who does not. Similarly, it was felt that a well-socialized respondent would consider her career very important after college, especially after just completing two years of school in order to advance in that career. Again, the paradigm and the literature review supported this notion. The third item was selected to contrast with the second. It was felt that a well-socialized student would give marriage a lower rating than would a student not so well socialized. We also wanted to see how this variable would compare to the second.

A number of independent variables were selected from the recruitment and socialization categories on the basis of whether they applied to the outcome variable, i.e., whether or not they would theoretically be associated with the chosen outcome variable. Each dependent variable was cross-tabulated with each independent variable. We then hypothesized the expected result of each interaction.

Findings

Since fifty cross-tabulations were run, we will not present all of the results of those runs here. To illustrate the nature of our findings, however, we have selected several interesting runs for discussion.

We hypothesized that the more encouragement a student received from her spouse for enrolling in a BA program, the greater would be her career commitment as indicated by the "personal stake" item (see p. 99). Our results showed no such relationship. (1) Most (68%) of the responses were not applicable, i.e., students were not married. (2) Across all response categories for "personal stake," the respondent's spouse was seen as definitely supportive. This lack of variation was unexpected. For example, we expected that a student who had only a moderate degree of personal stake in her nursing identity might have a husband who was either ambivalent or not supportive. (3) With one minor exception, across all levels of spousal support, respondents consistently indicated that they had a "very great" personal stake in their nursing identity. Again, we had expected more variability. Because there was no variability, our hypothesis was not supported.

Two other cross-tabulations also used the "personal stake" item as the dependent variable. Independent variables were "Would you recommend the field of nursing to your son?" and "Would you recommend (it) to your daughter?" We hypothesized that the amount of encouragement given to a hypothetical son or daughter who was interested in nursing would be directly related to career commitment. Across all response categories of personal stake, however, respondents indicated that they would "definitely" or "mildly" encourage both the son and the daughter. Again, this lack of variation was unexpected; and our hypothesis did not hold.

This finding, of no variability, applied across _all_ cross-tabulations for _each_ outcome variable and each independent variable used. Not one of our hypotheses was borne out by the results of the cross-tabulations. However, none of them were the reverse of what we expected either. The lack of variation simply resulted in _no_ significant relationships--positive _or_ negative.

Discussion

Our speculative interpretations of such findings branch out in three directions. One, the women in our sample may simply be very similar to one another. All the students are highly motivated; all think that a career is going to be very important after college, etc. Either the institutional selection process for Second Step programs, along with the further self-selection of the students, creates this remarkably homogeneous group; or the nursing field in general, because of its particular qualities, "selects" a remarkably similar group of people.

A second possibility is that we need to look at multiple causes simultaneously in order to see any variation among the group. This, however, is not too likely because of the previously mentioned results of our multiple regression analysis.

A third possibility may be that the paradigm itself is incorrect, since predictions based upon it were not supported in our data. Before we can endorse this last possibility, however, a closer look at the data and a re-evaluation of the findings should be conducted.

In conclusion, our results were not at all what we expected; and we still are not completely sure as to why. The lack of sufficient variability in the sample is the obvious and immediate cause, but that in itself is an interesting finding. Along with the self selection that goes on prior to the students reaching Second Step programs, there must be further institutional selectivity, both of which operate to make studies of this nature difficult to conduct. If future socialization studies of these programs attempt to predict outcomes on the basis of personal and institutional characteristics, then more sensitive instruments will have to be developed in order to pick up and maximize whatever differences exist. We may also want to modify the paradigm in order to make it more applicable to the study of adult socialization into the profession of nursing.

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CHARACTERISTICS OF NOVICE AND EXPERT PERFORMANCE: IMPLICATIONS FOR TEACHING THE EXPERIENCED NURSE

Patricia Benner

Second Step nursing education programs offer nursing a golden opportunity that any discipline might envy. This opportunity is at least three-pronged:

> The opportunity to teach students with rich experiential backgrounds that prepare them to make discoveries and leaps in their knowledge instead of small incremental steps.
>
> Educators get a second chance to influence nursing practice by preparing graduates who have already grappled with reality shock and who may quickly return to leadership positions.
>
> Teaching the experienced nurse offers many opportunities for knowledge development since nursing knowledge is embedded in nursing practice.

This enviable moment gives nursing educators an opportunity to assist experienced practitioners to examine their practice and build on what they already know. It fills their classrooms with students who have grappled with reality shock and, therefore, have strongly felt needs about what they need to learn in order to better equip themselves for practice. An educator could not ask for students more prepared for discovery, not to mention the joy of skipping the fundamental skills lab.

But what if we stamped and certified all returning RNs as educated without transforming their practice--without building on their strengths and equipping them to push their practice out into areas that were beyond their former educational level? We might successfully beat down the barriers to upward mobility and cut out the frustrating tangles

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and hurdles, but we would miss a golden moment in nursing's history. And we would contribute to the personal disappointment of every expectant RN who views additional formal education as the last hope for salvaging a nursing career.

Now I know that not all Second Step students enter their programs so positively expectant. Dr. Virginia Carrieri and I conducted an evaluation study for the extended degree program at the University of California, San Francisco. We found that many RNs return with low expectations and cynicism. Many told us that they returned to school to shed their second-class-citizen status and to prove that they knew as much as anyone with a degree. But even the most cynical student enters the Second Step program with an experiential base to build upon. The educator has the opportunity to help them make visible this knowledge which is embedded in practice, and to help them further refine and develop that knowledge. But to seize these opportunities, educators must have the right tools and strategies to work with the experienced student.

The experienced nurse returning for additional formal education comes with a rich readiness to learn and offers nursing education a second chance to influence practice, but I want to focus on the third opportunity offered by the Second Step program--the opportunity for knowledge development. The experienced nurse returns with a wealth of knowledge embedded in her or his clinical practice. No other helping professionals spend as many clock hours in direct observation and clinical assessment as do nurses. But for many reasons--the most important one being our cultural bias against informal experiential learning--we have not legitimized or credited the knowledge which is embedded in clinical practice. Much of our language, formal models, and analytical practices serve to make that experiential knowledge invisible and uncredited to us. The invisibility of such knowledge is a particular handicap to seasoned nurses returning for more formal education if those programs are not equipped to maximize and build on what they already know. The Second Step student offers the educator a unique opportunity for describing and crediting what is learned through experience, and for making visible to the returning student, and to nurses in general, can be recognized without situational experience. They are also taught rules to guide action in respect to different attributes. The following is an example from nursing of such a context-free rule:

> To determine fluid balance, check the patient's morning weights, daily intake and daily output for the past three days. Weight gain and an intake that is consistently higher than output by greater than 500 cc. could indicate water retention, in which case fluid restriction should be started until the cause of the imbalance can be determined.

Rule-governed behavior typical of the novice and the limitations inherent in such behavior is described in the following selection from an interview with an expert intensive care nursery clinician:

> I give instructions to the new graduate, very detailed and explicit instructions: When you come in and first see the baby, you take their vital signs and make the physical examination, and you check their I.V. sites, and you check their stand-by ventilator and make sure that it works, and you check their monitors and alarms. When I would say this to them, they would do exactly what I told them to do, no matter what else was going on ... they couldn't choose one to leave out. They couldn't choose which was most important ... They couldn't do for one baby the things that were most important and then go to the other baby and do the things that were most important, and leave out the things that weren't as important until later on.

This then is the heart of the difficulty that the novice faces. Since novices have no experience of the situation they face, they must be given rules to follow to guide their task performance. But the following of the rules legislates against successful task performance because the rule cannot tell them what are the most relevant tasks to perform when in an actual situation.

Hubert and Stuart Dreyfus use the example of language learning and pilot training. The novice acquiring a second language has learned the phonetic rules for producing and recognizing what seemed to be meaningless noises that get specific results when produced on specific occasions. The novice pilot knows how to read cockpit instruments and how to manipulate the controls in response to such features as instrument readings, and context-free visual cues such as the angular displacement of the horizon.

We do not need to spend a great deal of time on the novice stage; experienced nurse clinicians returning to school will approach only a few areas of practice from a novice perspective. The danger is that we will inappropriately insist that the experienced nurse use and cite context-free rules and principles that they have long since discarded. There are at least two undesirable outcomes from such unwise practice:

> Students lose, temporarily at least, their confidence in their own knowledge and ability, and
>
> Educators lose credibility in their students' eyes because it is not difficult for the experienced nurse to point up the many exceptions to the context-free rule.

It would be useful to have students clarify for you those areas of practice proposed in your program that are completely new to them, and thus appropriate for novice-level teaching strategies.

Competent State: Once the performer has experienced many situations s/he begins to move on to the competent stage. Novices can take in little of the situation--it is too new, too strange; and besides, they have to concentrate on remembering the rules. As the expert clinician quoted above goes on to note:

> If I said you have to do these eight things ... they did those things, and they didn't care if their other kid was screaming its head off. When they did realize, they would be like a mule between two piles of hay.

The competent performer, however, with a background of accumulated experience, begins to perceive, often with the help of the instructor, reoccurring and meaningful patterns.

The instructor formulates principles dictating actions in terms of aspects. In the Dreyfus model, the term "aspects" has a very specific meaning. Aspects are not like the context-free attributes or features that the novice uses. Attributes of the situation such as intake and output, or the procedural list of things to do for the baby, do not require the person to have any prior experience. But aspects do require experience for recognition. Aspects include overall characteristics, global characteristics; without prior experience, the performer cannot recognize them. For example, assessing a patient's readiness to learn depends on experience with previous patients with similar experiences and similar teaching-learning needs. An expert clinician describes her assessment of a patient's "readiness to learn" about his continent ileostomy this way:

> Earlier I thought he was feeling helpless about the operation he had just had. He looked as though he felt crummy -- physically, sort of stressed-looking, nervous-looking. Furthermore, he was treating the wound physically very gingerly. He didn't need to be that gentle with it. But on this morning, it was different, he began to ask questions.

The instructor can provide guidelines referring to aspects such as readiness to learn, for example: "Notice whether or not the patient asks questions about the surgery or the dressing change." "Observe whether or not the patient looks at or handles the wound." But these guidelines are dependent on knowing what these aspects sound like and look like in a patient care situation. Notice that while aspects may be made explicit, they cannot be made completely objective. The way the patient asks about the surgery or the dressing change makes a difference. You have to have some experience with prior situations before you can use the guidelines. Aspect recognition is dependent on prior experience.

Most generic programs work for competence in their graduates' performance. In their advanced clinical courses, much time is spent on aspect recognition. If you teach physical assessment in your own program, aspect recognition may become an appropriate learning goal for the experienced nurse untrained in physical assessment. Students, for example, may practice discriminating between breath sounds indicative of pulmonary edema and those indicative of pneumonia. Or if you are teaching assessment of family health needs, certainly aspect recognition will be a learning goal for the experienced RN. But in all those courses where the clinician has already attained competence, aspect recognition will probably be redundant, and it will be possible to focus on the more advanced clinical skill of judging the relative importance of different aspects of a situation. This more advanced skill--judging the relative importance of different aspects of the situation--leads us to the next step of skill acquisition: proficiency.

Proficient Stage: With continued practice, the competent performer moves to the proficient stage. Characteristically, the proficient performer perceives situations as wholes rather than in terms of aspects, and performance is guided by maxims.

The proficient nurse understands a situation as a whole because s/he perceives its meaning in terms of a long term goal. The intensive care nursery experienced clinician describes her awareness of the recognition of the whole situation as a requisite of the proficient stage.

> I think the biggest thing that's been on my mind for the last few weeks was whether I would be able to say at the end of the three-month period that the new graduates could give safe care independent of me. Does she know how to manage the nursing care, or does she just know how to do specific tasks? To my mind, moving the child from Point A to Point B is what nursing is all about. You have to perform tasks along the way to make that happen, but performing the task isn't nursing ... I wanted to see a light going on--that o.k., here's this baby, this is where this baby is at, and here's where I want this baby to be in six weeks. What can I do today to make this baby go along the road to end up being better? It's that kind of thing that's just happening now. They're just starting to see the whole thing as a picture and not as a list of tasks to do.

Whereas, the competent person does not yet have enough experience to recognize a situation in terms of an overall goal or in terms of which aspects are most salient, most important, the proficient performer now considers fewer options, and hones in on an accurate region of the problem. Aspects stand out to the proficient nurse as being more or less important to the situation at hand. The expert nurse, in talking about the patient's readiness to learn about his continent ileostomy, said that she was glad she was able to stop everything and spend an hour and a half with the patient at the precise moment that he was most ready to learn. One can speculate that postponement would have been as unfortunate as a premature attempt to teach. Thus, aspects stand out to the proficient nurse as being more or less important in terms of the situation at hand. Maxims are used to guide the proficient performer. But a deep understanding of the situation is required before a maxim can be used. Maxims reflect what would appear to the competent or novice performer as unintelligible nuances of the situation, but once one has a deep understanding of the situation, the maxim provides directions as to what is important to take into consideration. Maxims reflect nuances of the situation which can mean one thing at one time, and quite another at another time. This is revealed in the experienced nurse clinician's account of how she weans a patient from a respirator:

> Well, you look at their vital signs to see if there is anything significant in their vital signs. But even here you need to do a little guessing, in terms of whether the patient is just anxious because they are so used to the machine breathing for them ... If they get a little anxious, you don't really want to medicate them, because you are afraid they will quit breathing; but on the other hand, they may really need to calm down a bit, so it just depends on the situation. It is a real experiment. You have your groundwork, from what you have done in the past, and you know when you are going to get into trouble.

Proficient performers are best taught by use of case studies which solicit and build upon their ability to grasp the situation. To provide proficient performers with context-free principles and rules will leave them frustrated and will usually stimulate the experienced nurse to provide examples of situations where clearly the principle or rule would be contradicted. When this happens, proficient performers can come to feel that theory is a useless trapping. Or they may view the educator's elaborate decision analysis as the hard and unnecessarily elaborate, slow way to solve a clinical problem that they can grasp quickly by virtue of their experience. This will particularly be the case if the theory you are using is appropriate for teaching the beginner how to approach situations safely, and, thus, is not appropriate for describing or explaining more complex or subtle aspects of the situation. The proficient performer is best taught inductively. The student begins with a clinical situation and then supplies her/his ways of understanding it. When situations are introduced that exhaust the experienced nurse's understanding and approach, then you have found a fruitful area of learning. You can develop these case studies by having proficient clinicians supply two kinds of case studies from their own practice: (1) situations where they felt successful and where they think their intervention made a difference; and (2) situations where they were not satisfied with their performance, or felt conflicted or confused by the situation.

Expert Stage: At the expert level, the performer no longer relies on an analytical principle (rule, guideline, maxim) to connect her/his understanding of the situation to an appropriate action. The expert nurse, with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful possible problem situations or solutions.

It is very frustrating to try to capture verbal descriptions of expert performance because the expert now operates from a deep understanding of the situation. The chess master when asked why he or she made a particularly masterful move will just say: "Because it felt right." "It looked good." Or you ask expert business decision makers about what factors they would identify and what weights they would give them for a decision on whether a product should be brought out quickly at some risk, or whether more time should be spent in testing and development, and you would most likely get an answer like, "Well, it all depends." And they would ask for more information.

The problem experts have in telling all they know is evident in the following excerpt from an interview with an expert psychiatric nurse clinician. She has worked in psychiatry for fifteen years and is highly respected by both nurse and physician colleagues for her clinical judgment and ability in working with patients:

> When I say to a doctor, 'the patient is psychotic,' I don't always know how to legitimize that statement. But I am never wrong. Because I know psychosis here (she points to her gut). And I feel that, and I know it, and I trust it. I don't care if nothing else is happening, I still really know that. It's like the feeling another nurse described in the small group interview today, when she said about the patient 'she just wasn't right.' One of the things that I am doing now is getting some in-service in to talk to us about language. But all I am trying to do really is to find words within the jargon to talk about something that I don't think is particularly describable.

This nurse went on to describe a specific situation in which she knew that a patient was being misdiagnosed as psychotic when the patient was not psychotic, but rather was extremely angry. The physician was convinced that the patient was psychotic, and said, "We'll do an MMPI to see who's right." This nurse responded, "I am sure that I am right regardless of what the MMPI says." Fortunately for the MMPI, the results backed up the nurse's assessment. I say fortunately, because, on the basis of her assessment, this nurse began what was a very successful intervention for the patient. An aside is in order here. No other helping professionals spend as many clock hours in direct observation of patients as do nurses. It is time that we begin to credit what we learn from this observation, this experience.

Hubert Dreyfus (1980) notes:

> As long as the beginner pilot, language learner, chess player, or driver is following rules, his performance is halting, rigid and mediocre. But with the mastery of the activity comes the transformation of the skill which is like the transformation that occurs when a blind person learns to use a cane. The beginner feels pressure in the palm of the hands which can be used to detect the presence of distant objects such as curbs. But with mastery the blind person no longer feels pressure in the palm of the hand, but simply feels the curb. The cane has become an extension of the body. (Public Radio Broadcast)

A similar transformation occurs with the expert nurse clinician's tools. Dreyfus (1980) describes the experienced performer:

> The performer is no longer aware of features and rules, and his/her performance becomes fluid and flexible and highly proficient. The chess player develops a feel for the game; the language learner becomes fluent; the pilot stops feeling that s/he is flying the plane and simply feels that s/he is flying. (Public Radio Broadcast "Options," 1980)

Now, all of this is not to say that the expert never uses analytical tools. Highly skilled analytical ability is necessary for all those novel or new situations where the nurse must depend on analytical tools for solving the problem. Analytical tools are also necessary for those times where the expert gets a wrong take, a wrong grasp of the situation and finds that events and behaviors are not occurring according to expectations. The only way out of a wrong grasp of the problem is analytical problem solving.

I think it is the expert nurse clinician returning for more formal education that presents the greatest challenge and the greatest opportunity to the nurse educator. First, every effort should be made to recognize areas of expertise. It is precisely these areas that are ripe for knowledge development. By helping the expert to describe clinical situations where her/his intervention made a difference, some of the knowledge embedded in the expert's practice becomes visible both to the expert and to the educator. What experts can make visible, however, is not the expert level of performance. At most, they can describe and make visible the proficient level; but this is a needed step in knowledge development in nursing practice.

Implications: An Interpretive Strategy

Gadamer (1970) and other continental philosophers call our attention to the exclusion of an adequate view of experience in the rational and empirical traditions. Gadamer (1970) refers to experience as a non-objectified and largely non-objectifiable accumulation of understanding, which is often called wisdom. A nurse who has dealt with many people acquires a rich basis on which to interpret new situations, but this multifaceted knowledge with its concrete referents cannot really be put into conceptual terms.

We hope to study the implications of the Dreyfus Model of Skill Acquisition in nursing more systematically in the next year. But it does appear at this point that the novice is best taught from the competent perspective; the competent from the proficient perspective; and the proficient from the expert level. It is important to note that there is a leap, a discontinuity, between the competent level and the last two levels. If the expert is made to attend to the particulars, or to a formal model or rule, her/his performance actually deteriorates. It is equally important to emphasize that this view of skill acquisition does not posit that the rules and formulas just become unconscious, or go underground. This argument cannot be made exhaustively here in the time allotted, but has been made in Hubert Dreyfus' book, What Computers Can't Do: A Critique of Artificial Intelligence.

To get a feel for this model of skill acquisition, think of your own experience learning to ride a bicycle, drive a car, speak a second language or give an injection. I could as easily say engage in helping relationships, but relational skills may be more difficult to trace. When you first begin, your performance is halting, rigid, and you must pay attention to explicit instructions. Your performance is rule governed. Now, our Western tradition posits that with experience and mastery of the skill, all these rules just become unconscious. But this claim flies in the face of all evidence of masterful performance and ignores the role of the body in skilled performance. Hubert Dreyfus (1980) reports some air force studies which demonstrate that it is only by dropping the rules that you can become really proficient. For example, undergraduate pilots are taught to follow a fixed sequence of visual scanning of instruments and dials. But researchers found that the instructors, who were giving out these rules, could find errors in the visual displays much more quickly than the trainees. They wondered if the instructors simply applied the rules much more quickly and much more accurately than the student pilots, so they checked their eye movements and found that the instructors weren't using the rules that they were instructing the trainees in at all. It was just in this way that they could do so much better in the novel scanning tests than the trainees using the rigid scanning patterns. Thus, an important assumption of the Dreyfus Model of Skill Acquisition is that the skill is transformed, it is changed with mastery, and that this change brings about improvement in the performance. And if you insist that the expert pilots, for example, pay attention to rules and guidelines that they may have used when they were beginners, their performance deteriorates.

One implication of the Dreyfus Model of Skill Acquisition is clear without further study. Expert, or even proficient performance, cannot be captured or described by formal models, decision analysis, or strategies which are adequate for the novice and competent levels but which are woefully simple and inadequate for the advanced levels of clinical performance. Struck with this problem of presenting an adequate description of the proficient and expert performer, we have pursued an interpretive approach to describing nursing practice that I think could be a very useful tool for helping the experienced nurse describe her/his own practice, and thus for making visible some of the knowledge embedded in practice.

An interpretive strategy is synthetic, rather than analytic, and focuses on meanings as a way of organizing and describing practice. This allows an economical, yet rich description of nursing practice. On the AMICAE Project, we have now conducted over 150 interviews, done participant observation in four hospitals, and have identified 15 competencies thus far by using a situation-based interpretive approach. The interpretive approach we are using is rooted in the work of Heidegger (1962) and Taylor (1971) and has recently been presented as an alternative methodology for the social sciences by Rabinow and Sullivan (1979).

The model of study resembles the interpretation of a text. A sentence, for example, cannot be understood by analyzing the words as constituent elements alone. Rather, one understands a sentence as part of a larger whole, and interprets its meaning from the context of the text in which it is found. Similarly, behavior can be seen as having potentially multiple rather than single meanings. To understand behavior, therefore, one must look at it in its larger context. This can be easily illustrated with a familiar example of nursing care. The meaning of a bed bath changes with the changes in the health status of the patient. Early in a patient's illness, a bed bath may be an essential comfort measure. With increasing recovery, this very same bed bath may mean the excessive fostering of dependence. Thus, a bed bath, when considered in the abstract can have multiple meanings or functions (e.g., hygiene, stimulation, etc.). To understand its specific meaning, however, one must know the specific context in which it is given. Understanding the situation inherently limits the many possible meanings of behavior into manageable and relevant wholes.

Furthermore, with an interpretive approach, the intentions and empathy of the actors are taken into consideration and seen as dependent on a shared world of meanings. Intentions and empathy are not seen as privately held, but rather are viewed as pre-existent in the culture and therefore accessible to interpretation. An interpretive approach avoids the problem of the infinite list of tasks, with no guidelines for determining which are most important. The meaning of the situation is maintained rather than stripped away to objectified, context-free (de-situated) traits or behaviors.

Two illustrative examples of competencies identified using an interpretive strategy are given on page 117. Note that neither competency is adequately identified by its label; both are, instead, dependent on the exemplars. The exemplars serve as paradigms. Once you have adequate exemplars, you can recognize other similar situations even though many of the objective features may be quite different. In other words, the focus is on the gestalt of situations, rather than on breaking them down into specific tasks.

These two illustrations, or examples, were selected from an in-progress list of 15 such competencies. They serve as examples both

TWO AREAS OF SKILLED PERFORMANCE

1. The Healing Relationship: Creating a Climate for and a Commitment to Healing.

A number of the clinical episodes in which nurses have through their intervention made a difference in patient progress presented evidence that a healing relationship was established between the nurse and the patient. Several steps are evident in this relational process:

- Mobilizing hope for the nurse as well as for the patient.
- Finding an acceptable interpretation or understanding of the situation (e.g., illness, pain, fear, anxiety, or other stressful emotions).
- Assisting the patient to use social support.

The Healing Relationship--Exemplar

An expert clinician described taking care of a young woman hospitalized for the first time with an advanced breast cancer. The woman was the mother of a young child and lived in a communal family. She had tried alternative sources of healing for her breast cancer, and these strategies had failed. She was now emaciated and had an advanced growth and open wound on her chest. As an interviewer, I noticed that the nurse had made a commitment to the patient. She checked in on her when she wasn't assigned to her and she thought about her while she was away skiing. I asked when that commitment occurred.

EXPERT NURSE: The first day I met her.

INTERVIEWER: Tell us a little about that first encounter.

EXPERT NURSE: The only other cancer I had seen like that was when I was a student nurse (more than 20 years ago). That came back to me very vividly when I walked into the room with her. And the first patient I had, died. I had the feeling that this patient had the possibility of a good quality of life, if ... and I read her notes closely, she had radiation therapy and chemotherapy and a good diet, and so forth, that her life span could be 8-10 years. Or maybe she even had a chance for a complete cure. And that to me was a challenge--to work with somebody like that. To support her in changing her lifestyle.

SUMMARY STATEMENT: The nurse described her interactions with this patient over the course of the next few weeks. She found out the patient's interpretation of her illness, and encouraged her to be more assertive by allowing her to practice with her and the rest of the health care team. She helped the patient work through the issue of increasing the protein in her diet. She helped her assert her needs to family members. The outcome was that the patient decided to have traditional medical treatment, radiation and chemotherapy augmented by her own systems of support and ways of healing. The sense of hope and concrete strategies offered by the nurse along with the nurse's expert interpretive skills enabled this young woman to embark on a therapeutic regime which enabled her to leave the hospital with a healed wound and a sense of hope and possibility. The narrative reporting is highly suggestive that the nurse was a key person in mobilizing the young woman's hope and enabling her to choose a course of action.

In this exemplar, the nurse mobilized her own hope as well as the patient's, found an acceptable interpretation or understanding of the situation, and helped the patient use social support. These processes are not described as intentional goals by the nurse, but rather emerge as part of the cultural tools of nursing. The successful nurse knows how to engage in these processes.

2. The Nurse as an Early Warning System: Anticipation of Deterioration Prior to Explicit Confirming Evidence.

We have gathered a number of stories of the nurse anticipating deterioration before the evidence was convincing in terms of change in vital signs, or other measurable evidence. When the stories are examined carefully, the nurse is not using blind intuition, but rather is picking up on subtle changes in the patient's behavior or appearance which are different from earlier observations.

The Early Warning System--Exemplar

EXPERT NURSE: We had a patient who had an esophageal dilatation in X-ray. She was a very uncomplaining woman, about 60 years of age. When she came back, her vital signs were o.k.; and she was up to the bathroom. Later she started getting nauseated, and she had streaks of very light pink drainage which I could account for by the dilatation procedure; but I just had this feeling that something else was going on. She became worse; she became nauseated. I called the house officer. Her vital signs were still stable, and I indicated that I wanted the house officer to check her. The house officer examined her but was not ordering any tests. I wanted to order blood work. I pointed out that the patient's nail beds were cyanotic. The house officer was unimpressed. It was almost time for me to go off duty when the patient started having chills with a temperature, so I called the house officer again and said that there was something going on with this patient, and that I wanted to see something done for her before I went off duty. Later I found out that the patient had a rupture in her esophagus; she also had aspiration pneumonia. Her pulse had gone up to 150. The house officer credited my persistence in getting early treatment in making a difference in the patient's outcome.

SUMMARY STATEMENT: There are a number of examples of early detection of a change in patient status which turn out to be accurate. The effectiveness of this competency, however, gets linked with the nurse's skill in getting an appropriate and timely response from the physician. As educators, we do the clinical experts who return for more education a disservice when we teach them to devalue their intuition which is based on clinical experience.

of the situation-based, interpretive method, and of the kinds of areas of skilled performance that have been uncovered by means of this method. These competencies avoid the limitations of those derived from other perspectives (e.g., job analysis, industrial psychology). They are not trivial, but are central to the process of nursing. They are not global, but are rooted in the real-life practice of nursing. I believe that knowledge is embedded in practice; only as we begin a detailed study of nursing practice, using our own language, will we uncover the unique knowledge which is nursing.

Summary

Teaching the experienced RN offers the nurse educator at least three major opportunities: (1) access to students whose rich experiential backgrounds prepare them for leaps and discoveries instead of small incremental steps; (2) a second chance to influence nursing practice through graduates immune to reality shock and ready for leadership positions; and (3) an unprecedented moment for essential knowledge development, since nursing knowledge is embedded in nursing practice.

To make the most of these opportunities, we must transform our educational programs. We will have to develop new strategies for advancing the clinical practice of the experienced nurse. The Dreyfus Model of Skill Acquisition as applied to nursing offers a perspective which can help us address the learning needs of returning RN students so that they indeed graduate better equipped, more competent, and in many cases with their nursing practice transformed. But to do this, we need to change our language and our ways of describing nursing practice. I think the interpretive approach offered here is a viable alternative. I encourage you and your experienced students to experiment with new ways of describing nursing practice, and to be guided by Polanyi's observations on skill acquisition for the physician:

> Although the expert diagnosticians ... can indicate their clues and formulate their maxims, they know many more things than they can tell, knowing them only in practice, and as instrumental particulars,

> and not explicitly as objects. The knowledge of such particulars is therefore ineffable, and the pondering of a judgment in terms of such particulars is an ineffable process of thought. This applies equally to connoisseurship as the art of knowing and to skills as the art of doing. Therefore, both can be taught only by aid of practical example and never solely by precept. (Polanyi, 1958, p. 88)

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Panel Discussion I

VALIDATION ISSUES: MYTHS AND METHODS

Moderator: Betty Marcom, R.N., M.S., Professor of Nursing
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A Vote for Cognitive Testing

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Alternatives to Testing: The CAEL Perspective

Jerry Dean Durham, Ph.D., Assistant Professor
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Credit by Examination: An Important Linkage in Education

Odessie G. Taylor, Ph.D., Associate Professor
and Associate Dean
College of Nursing
University of Nebraska
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Validating Clinical Competence Through Simulation

Eloise Lynch Werlin, R.N., Ph.D.
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A word about the panels . . .

Feedback from the National Second Step Project's 1980 research conference convinced us that one of the primary values for participants stemmed from the opportunity for meaningful dialogue focused upon central issues facing Second Step nursing education. Three panel discussions were scheduled to expand that opportunity in the 1981 conference.

The session reported here dealt with a basic issue peculiar to this curricular model: how to reconcile the seeming discrepancy between the State's position that RNs are already licensed as safe practitioners and the Academy's position that such licensure is insufficient evidence of their readiness to undertake an upper-division nursing program. Space limitations prevent our inclusion of the discussion in its entirity. However, the introductory remarks of each invited panelist are presented on the following pages, and the leading questions around which the discussion revolved are presented below.

- Why is it necessary to validate prior learning by means of testing? Haven't all applicants proven themselves by passing the State licensure exam?
- How costly is validation both in terms of actual expenditures required of the school and of the applicants, and in terms of loss of potential students who may get turned off by the whole testing process? Do testing methods themselves discriminate amongst applicants in the way you intend them to?
- Is it necessary to validate the prior learning of A.D. graduates as well as Diploma graduates? Does your institution accept other credits from these same institutions of higher learning? Is your policy potentially discriminatory?
- How do you validate or give credit for knowledge gained through work experience? Is it appropriate to do this? What about challenge exams for courses that are part of the Upper Division curriculum?
- Should clinical competence be validated as well as cognitive knowledge? What are the best means of accomplishing this?
- How do you go about "validating" your validation procedures?

A Vote for Cognitive Testing

Donna Arlton

My particular interest and involvement with validation of prior learning for registered nurse students began about six years ago when my faculty and I implemented a Second Step nursing program at Metropolitan State College in Denver, Colorado. We have continued to struggle with this issue ever since. As we gained experience in validating the knowledge of RNs in our program, we have gone through several phases in our thinking.

Initially, the position of the faculty was that we should require no entry testing to validate prior knowledge, neither for cognitive knowledge nor for clinical performance. After all, these persons had successfully graduated from a state-accredited nursing program and had passed a licensure examination. We did, however, require diploma nurses to take a group of four examinations designed by the National League for Nursing in order to translate their prior nursing education into lower division college credit. We are now using another group of tests, the Nursing Proficiency Examination Program tests published by the American College Testing (ACT) program.

Over a period of several years, we noticed that students who were having the most difficulty in our program were those who had graduated five, ten or more years ago from a basic associate degree nursing program and most likely lacked recent clinical practice experience. We also noted that at least two-thirds of our associate degree graduates came from programs not accredited by the NLN. Based on these data, the faculty decided to administer cognitive tests to both associate degree and diploma students.

From the faculty's perspective, there are two purposes for entry testing. One purpose is to make certain that entering students have a current minimal base of nursing knowledge; the other purpose is to serve as a challenge examination for which college credit can be given.

When RN students have gaps in their previously learned nursing knowledge, due to the passage of time or lack of use, they may be seriously handicapped in performing successfully in upper division nursing major courses. Therefore, it seems reasonable that all entering RN students validate by testing that they have at least a certain identified minimal knowledge base with which to synthesize new learning.

For the diploma RN student, the validation test doubles as a challenge examination; and lower division nursing credit is awarded for successful achievement on the tests. When the associate degree RN student demonstrates that her knowledge is current, then her previously earned nursing credits are accepted for lower division nursing transfer credit.

The faculty strongly believes that the purpose of entry testing is not to keep students out of a program, but it is to help insure that students can be successful in the baccalaureate program. Students are provided with study guides and are allowed to repeat failed examinations. If they prefer, they may elect to take a course in the failed area.

There has been much emphasis on testing clinical performance skill as well as cognitive knowledge prior to entry into a Second Step nursing program. The experience of many faculties around the country indicates that these procedures are costly in terms of time and human resources, and that the validity and reliability of such testing as carried out by various programs is in question. As an alternative to performance testing, my faculty requires a full year of successful clinical practice within the past three years, or in lieu of that, a nursing refresher course with clinical supervision within the past year. A letter of reference from a current employer which verifies the student's clinical skill competency is required of each entrant.

I do not mean to imply that faculty should be discouraged from testing the clinical competencies of students. It is, however, a difficult task. I would recommend for your examination two recent publications on this topic: The Clinical Performance Examination by Carrie Lenburg and Evaluation of Nursing Competence by Harriet Schneider.

In addition to the question of entry testing, my faculty has struggled with determining if and how much the student should be allowed to challenge upper division nursing courses. Should they be allowed to challenge courses with a laboratory component? Should they be given credit for life experience?

It appears to me that the questions are easier to identify than the answers. I hope that today each of us will be able to share our questions, opinions, our findings, and our successes as they relate to validation of the RN student's knowledge.

Alternatives to Testing: The CAEL Perspective

Jerry Dean Durham

In the past few years, many instruments have been developed to assist educators in evaluating college-level learning which has taken place both inside and outside of the classroom. These instruments have been widely discussed in the literature; they represent one means by which schools of nursing can determine whether learning has occurred and whether college credit should be granted for that learning. That schools of nursing generally use paper-and-pencil tests to validate this prior learning is evidenced by the data contained in the National League for Nursing's Director of Career Mobility Programs in Nursing Education, 1976, and by the findings of a national survey which I conducted in 1978. These paper-and-pencil tests are of two types, teacher-made or standardized, each with inherent advantages and disadvantages. While many registered nurses seeking admission to baccalaureate nursing programs have questioned the necessity of validating their knowledge by passing written examinations, this educational practice is now widely accepted in baccalaureate nursing education.

There exists little evidence that collegiate schools of nursing grant credit to nurses for learning which may have been acquired outside of the formal classroom setting. The use of proficiency examinations, according to Laverdier (1977), "has always been a commendable practice, but beyond that we might do well to consider the valuable knowledge gained from the lives and jobs of these registered nurses since completing their basic nursing program."

This prior learning, sometimes referred to in the literature as "experiential learning," is not entirely amenable to validation methods widely employed by nursing educators today. Experiential learning may be thought of as self-directed, non-sponsored, non-traditional learning which may occur at any point in the nurse's career prior to admission to a baccalaureate nursing program. Some nurse educators are skeptical about the legitimacy of this type of learning; they are concerned about the implications for nursing practice and for the movement toward professionalism in nursing. Thus, few opportunities exist today for the experiential learner to validate an accumulation of nursing knowledge by any means other than by passing written examinations. While it is widely recognized that RNs entering Second Step programs are adult learners, often with unique needs, these candidates are nonetheless subjected, for a variety of reasons, to written tests which may not always validate the scope of their nursing knowledge.

At least one organization, the Council for the Advancement of Experiential Learning (CAEL), has devised and utilized non-test methods to validate experiential learning. While this organization's methods also include testing, it is possible that their non-test methods may have special relevancy to assessing registered nurses' experiential learning. These methods include the use of expert judgment, expert panels, product evaluation, student portfolios, oral examinations, job performance ratings, and performance examinations, many of which have been utilized nationwide in adult education programs.

Validating learning by non-test methods is neither simple nor in many cases inexpensive--factors which may limit the use of such evaluation procedures. Another argument which questions the appropriateness of using non-test methods to assess experiential learning focuses upon problems of validity of such procedures. Still other educators fear that accrediting agencies would not approve programs which use methods other than paper-and-pencil tests to evaluate experiential learning. My own research revealed that many nurse educators are not familiar with experiential learning theory and evaluation processes, and that some nursing faculties openly oppose granting credit for this kind of learning.

The issue of evaluating prior learning is emerging as an urgent issue confronting nurse educators in the 1980's. As greater numbers of registered nurses seek the baccalaureate degree, pressure will be exerted to devise flexible methods by which prior learning, including experiential learning, can be fairly and efficiently assessed. As greater numbers of baccalaureate programs become accessible to experienced nurses, as the competition for students in the educational marketplace intensifies, and as nurse educators become more aware of a societal and professional need to provide baccalaureate education to these students, more flexible means of assessing prior learning must emerge. It behooves nurse educators to become aware of these non-traditional assessment methods and to adopt those which are found to be appropriate for evaluating prior learning. Unless nurse educators study and use non-traditional educational processes in making baccalaureate education available to registered nurses, progress toward professionalism in nursing will continue to remain a dream and perhaps a myth for many years to come.

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Credit by Examination: An Important Linkage in Education

Odessie G. Taylor

The validation of previous learning so that credit can be awarded is problematic to many institutions of higher education. This problem is of special concern to baccalaureate programs in nursing as they admit and place registered nurse students who, having graduated from hospital diploma programs, do not have college credit for nursing courses. Various methods have been used in this validation process--requiring the nurse to repeat content, using locally constructed tests to assess knowledge and skills, or using National League for Nursing (NLN) achievement tests for that purpose.

To some, these various methods have not seemed completely appropriate or adequate; and they have sought more formalized or more widely accepted and standardized procedures comparable to the College Level Examination Program (CLEP) used by liberal arts colleges and others. Recently, the University of the State of New York developed the Proficiency Examination Program (PEP) for its External Associate Degree Program, and also had this program accredited by the NLN's Board of Review. In articulated or Two Plus Two baccalaureate programs, these examinations could be used to validate knowledge and to award credit by examination.

Since the initial norming procedures for the PEP examinations involved a limited eastern sample of associate degree graduates, a study was undertaken to validate these tests using a midwestern norm group. The research questions were concerned with whether the PEP examinations had predictive and concurrent validity with specific criterion measures; whether these test scores differentiated between high and low achievers within the norm group, and whether certain tests within the PEP battery were more useful than others.

The study sample, 227 associate degree graduates from the College of Nursing at the University of Nebraska Medical Center (UNMC), wrote selected PEP examinations and specific National League for Nursing (NLN) achievement tests just prior to graduation. Additional data included each graduate's cumulative grade-point average and State Board Test Pool Examination scores. For those graduates who continued through the first year of the baccalaureate program, course grades and cumulative grade-point averages were also collected. Various statistical procedures were used: descriptive procedures such as means, range, and standard deviation; and inferential methods such as the t-test, Pearson's r, and multiple regressions.

A summary of the findings derived from an analysis of the data follows. First, the PEP scores of the two norm groups were found to differ significantly. In all instances, UNMC mean scores were higher than those of the original New York norm group. Second, concurrent validity was established by correlational analyses. Relationships between scores on both SBTPE examinations and NLN achievement tests and the PEP exams were all positive and tended to be fairly strong. Students who scored high on the first two tests tended to have high scores on the latter test battery.

Third, the UNMC norm group was divided into two groups according to age (±21 years), whether they met baccalaureate admission criteria, and their PEP scores (±45 standard score). No conclusions regarding age were derived from the data. However, the PEP examinations did seem to differentiate between high and low achievers in the norm group. For example, students who did not meet BSN admission criteria had significantly lower PEP scores than those who did; and those whose standardized PEP scores were above 45 had SBTPE scores significantly higher than those with PEP scores below 45.

Fourth, through the use of multiple regression equations, three examinations in the PEP battery seem to account for most of the variance in SBTPE scores and cumulative grade-point average. From this fact, we could infer that those three tests could be used to award credit rather than using the complete test battery. Lastly, the PEP tests did not seem to provide predictive validity. This result may have been related to the limited number of students who had gone on to the baccalaureate program.

Based on the following criteria, recommendations were made regarding how to award credit by examination. (1) The instrument should be appropriately validated prior to its use. (2) Measurement is only one method in evaluation and provides one type of information; other spheres of proficiency should also be verified. (3) The process should be as economical as possible but should assist in educational mobility. (4) Limited knowledge exists regarding credit by examination; continued study and evaluation of its use are indicated.

Validating Clinical Competence Through Simulation

Eloise Lynch Werlin

The issue of validating that RN students possess a common core of technical knowledge and skills necessary to progress to upper-division nursing courses is a major concern of Second Step nursing programs. This is particularly important because prospective students represent diverse educational backgrounds--recent AD graduates from a variety of different curricula, diploma graduates, older RNs without recent nursing experience or education, etc.

Several instruments are available for testing theoretical knowledge: NLN basic achievement tests using AD norming groups; the College Proficiency Examination (CPE) tests in nursing; and teacher-made theory examinations. We at Pace initially selected the CPEs because they were already used by other departments in our university. A study correlating CPE scores with course grades from Pace's AD program provided further local validation. However, New York State's "Truth in Testing" law, requiring public disclosure of exams used for admission purposes, precluded the use of these exams. As a result, the B.S. faculty proposed that a series of three theory examinations (Medical/Surgical Nursing, Maternal and Child Nursing, and Psychiatric/Mental Health Nursing) be developed internally in time for testing prospective students of Fall, 1980. We are now in the process of establishing the validity and reliability of these tests.

Problems involved in testing application of knowledge have been explored by many professions, including nursing. For years, the most popular method of evaluating clinical knowledge was on a one-to-one basis, a process not only time-consuming and costly but also fraught with methodological problems. Evaluator's subjectivity as well as variability among patients constitute serious threats to reliability. Furthermore, a sample of behaviors adequate for a valid assessment may be impossible to achieve within the time demands of a "hands-on" performance situation. Thus, interest turned to simulation to assess clinical competence.

The National Board of Medical Examiners (NBME) began using simulated methods in lieu of bedside evaluations as part of their licensure test in 1961, citing two important advantages.[1] (1) The problem of evaluator subjectivity is eliminated since the examiner appears only through pretested multiple-choice questions and patient-management problems. (2) The problem of patient variability is eliminated since all examinees see the same films. These conditions allow for a reliable measure of the third and most important variable--the examinee's clinical competence. Furthermore, psychometric evaluation of the simulated methods demonstrated moderately high validity and reliability.

In nursing, too, the use of simulation to assess students' clinical problem-solving and decision-making skills has generated increasing interest.[2,3,4] Dincher and Stidger (1976) reported a significant (< .01) correlation between students' clinical judgment as evaluated by instructors, and their performance on a simulated tool. For these reasons, we at Pace decided to employ simulation to test for clinical competency.

The simulation format developed by the B.S. nursing department combines video-taped presentations of common nursing situations with audio-accompaniment. The 2-3 minute vignettes cover a range of technical nursing activities (interview, assessment, procedures, communication skills) with a range of clients of different ages and needs. By responding to a series of ten multiple-choice questions relating to each vignette, students make nursing judgments about whether and why the nursing action portrayed was performed correctly, or in an incorrect and unsafe manner.

The ultimate confidence in such an examination resides in its psychometric qualities. Content validity was determined by a group of B.S. and A.D. faculty, who decided on the content and test questions. Construct validity was approached both through item analysis and through the known-groups technique.

Both validity and reliability can be built into a locally developed test through carefully conducted item analysis based upon two measures:

item difficulty and item discrimination.[5] According to Anastasi (1976), item difficulty should average around .80 in a mastery test where it is assumed that the majority of individuals have mastered the basic knowledge/skills. Analysis of our examination revealed a mean item difficulty of .71. Item discrimination, as measured by biserial correlation coefficients, determines whether each item is discriminating in the same way as the overall test, thus operating to confirm the construct. In our analysis, the average biserial correlation was positive; the mean agreement of .19 suggests that, in general, a given item was operating similarly to the overall examination.

A second approach to construct validity, the known-groups technique, uses contrasting samples who are expected to differ on the critical attribute--in this instance, ability to apply clinical nursing knowledge. Here at Pace we compared a group of non-nursing business students with prospective nursing students. Out of 70 possible points, scores of the business students ranged from 19 to 37, with a mean of 31. Prospective nursing students scored significantly higher (< .01, t-test) ranging from 40 to 60 with a mean of 50. The finding suggests that the examination separates those who have and can apply clinical nursing knowledge from those who cannot.

Lastly, the reliability of the simulated clinical examination was further tested using the Kuder-Richardson formula 20 coefficient. The reliability coefficient (.58) was lower than expected. However, the relatively small number of items, as well as the heterogeneity of the behavior domains sampled may have contributed to this outcome.[6]

The process of validation, particularly of locally constructed tests, is a time-consuming task, principally due to the small number of students participating each year, and the need for continual refinement of the examinations. However, we at Pace remain committed to the use of a totally objective examination, and to the continued improvement of its psychometric qualities.

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Panel Discussion II

SECOND STEP PROGRAM DEVELOPMENT: FOUR UNIQUE APPROACHES

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The Articulated BS/MS Degree Program at UCSF

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The Felician Way

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Reaching Beyond the Campus in Nebraska

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Combining Quality with Flexibility at Pace

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A word about the panels . . .

Feedback from the National Second Step Project's 1980 research conference convinced us that one of the primary values for participants stemmed from the opportunity for meaningful dialogue focused upon central issues facing Second Step nursing education. Three panel discussions were scheduled to expand that opportunity in the 1981 conference.

The session reported here dealt with the unique processes and problems involved in developing a baccalaureate program for registered nurses. Space limitations prevent our inclusion of the discussion in its entirity. However, the introductory remarks of each invited panelist are presented on the following pages, and the leading questions around which the discussion revolved are presented below.

- Few new programs enjoy an abundance of funding. Most must start with limited amounts, often relying upon extramural funding for start up. Did you experience problems in this area? If so, how were they dealt with?
- Recruiting an adequate number of properly prepared faculty and assisting them in curriculum development and the selection of learning experiences for these non-traditional programs has posed problems for others. Has this been your experience? Can you share some approaches which were effective?
- Developing a Second Step program which meets the criteria for accreditation has proven to be problematic for a number of faculties. What resources were the most valuable to you in accomplishing this task?
- Many new programs encounter difficulties in funding research activities and in finding people who are research competent. Is research an integral part of your program? How are you able to keep research activities alive and well?

THE ARTICULATED BS/MS DEGREE PROGRAM AT UCSF

Elizabeth G. Nichols

The Articulated BS/MS Degree Program at the University of California, San Francisco is designed to meet many challenges: the health care system's need for leaders, the profession's need for mobility of talented individuals, and education's need for a variety of sound ways to provide professional preparation. Preparation of nurses at the graduate level (for that is the terminal point of the BS/MS program) is in keeping with the mission and tradition of the University itself: to continue to seek new knowledge, to convey its understanding to new generations, and to serve the citizens of the state in such areas as it has unique ability. Within nursing education, the University of California has traditionally emphasized graduate education and curricular innovation. The specific mission of the UCSF School of Nursing is to prepare leaders for the profession, to develop and test new educational programs, to seek and disseminate new knowledge and to design and test new health care delivery systems. Development and testing of this new curricular design for registered nurse students flows logically from the mission of the School.

The Program. The articulated BS/MS Degree Program has three major components: The prerequisites, the undergraduate component and the graduate component. Students transfer in at least 86 quarter units, including 15 units of upper division work. These units are distributed among fairly traditional content categories.

The undergraduate component of the curriculum includes 34 quarter units of credit by examination and 60 quarter units of upper division course work. Course work is built around the strands of physiological and psychosocial adaptation of individuals, families and groups in health and illness; individual, family and community assessment; social, political, economic and cultural influences on health care and nursing roles; and the nursing processes of research, problem-solving, change and leadership.

The Graduate portion of the program provides opportunity for specialization in one of a variety of clinical fields. Thirty-six units of academic course work and eight units of graduate professional work are required to qualify for the Master of Science degree, though individual goals may require additional study.

Common Issues.

1. Budget. Curriculum development was supported by intramural funds. Outside consultation, an off-campus workshop, initial evaluation tools, and support services were provided by the Dean's Office through creative budget management and the use of discretionary funds. A Special Projects grant was received in October 1980 to support continued program development and evaluation.

2. Faculty. Recruitment of faculty was not a particular problem; in fact, one reason for moving to this type of program was the belief that the skills and knowledge required for teaching in this program would be more compatible with qualifications already possessed by the faculty. It is difficult to determine whether faculty turnover was influenced by the decision to develop this program for many other changes, including a faculty development plan, were occurring during the planning period.

3. Program Development. During the summer and fall of 1977, a feasibility study addressed issues of potential RN student enrollment, curricular design, system constraints and supports, professional constraints and supports, and the political-social climate. The final report and recommendations of this study were presented to the full faculty for discussion, debate, and vote. The decision was a weighty one, for the program was to be in lieu of the generic baccalaureate program. That is, UCSF was not just adding an option for the RN student, but substituting programs.

The curriculum, itself, was influenced by a number of factors: The conceptual framework of the school, expected characteristics of students, interpretation of accreditation criteria, the goal of the program, and the structure of the school. A relatively equal distribution of courses between departments had to be achieved.[1]

Initially, ad hoc committees of the curriculum committee were appointed to develop the overall design and to identify critical content areas and sequencing. Frequent feedback to and from faculty members served to keep curriculum development as decentralized as possible so as to promote faculty involvement in, and commitment to, the program. Effort was also made to have the faculty who would be teaching the courses responsible for developing them.

Prerequisites were selected to supplement prior educational content, to prepare the students for graduate education, to permit maximum UCSF campus time for the upper division nursing major, and to permit the student maximum flexibility in meeting the prerequisites. Admission policies were set to be consonant with the philosophy of the school and the University, and to enhance the students' chance of success in the program.

4. Enrollment. Faculty positions in the U.C. system are generated by enrollment; therefore, a drop in enrollment results in a loss of faculty positions. With the new program, undergraduate student enrollment would drop from about 278 (139 per class) to about 189 in 1980-81 and to about 75 in 1981-82. To compensate, enrollment increases were planned in the M.S. and D.N.S. programs. There was continued concern as to whether enrollment figures would be met, for the general economic picture in the country did not encourage nurses to give up employment for graduate education.

5. Accreditation. Considerable communication with the National League for Nursing centered on whether the articulated program was a new program or a modification of an existing baccalaureate program. The League determined that the program was a modification, so no change in the accreditation schedule was necessary. Considered new, it would have been unaccredited, and an accreditation visit probably set for 1981, rather than the regular 1983 date.

6. Research. As one of the missions of the school is to test innovative educational programs, the research component of the program is particularly important. Our intent is to generate data useful to the school and to the nursing community in general. An extensive evaluation design has been developed to examine the curricular components of student,

faculty, and program.[2] The evaluation is partially supported by the Special Projects grant mentioned earlier, and is spearheaded by a committee of interested faculty, chaired by the Coordinator, Program Research and Development.

Summary: The School of Nursing, UCSF, in developing and evaluating its new articulated BS/MS degree program, is undoubtedly in a different situation from that of many other schools. The recruitment of faculty and the availability of research and curriculum expertise pose few problems. It's just as obvious, however, that other issues pose greater problems in this setting, e.g., maintenance of enrollment figures, consideration of the influence of UCSF on the nursing education community, and the political and social responses to closing the generic baccalaureate. UCSF faculty, like those in other schools, also must balance teaching, research and program development demands.

Notes

[1] At UCSF, the faculty is not grouped by academic program but by common interests and nursing foci: acute care, mental health, and community nursing; family health care; and social and behavioral sciences.

[2] Research questions address such issues as: the students' view of nursing practice, evidence of scholarship, learning styles of students, and post-graduation career choices; faculty's expectations of the program, faculty productivity, faculty's view of nursing practice and faculty teaching strategies; entry skills of students, articulation with graduate programs, flexibility of curriculum and course evaluation.

The Felician Way

Toni J. Sullivan

The Felician College upper division program offers a Bachelor of Science in nursing to registered nurses. The lower division is acquired prior to matriculation into the program, but the entire course of study--from freshman through senior year--is a carefully designed four-year sequence of professional and general education. One special curriculum feature is direct transfer of academic credit in nursing as well as in general education for graduates of NLN accredited Associate Degree programs. Another feature is an upper division curriculum model which challenges the learner to function as a professional nurse beginning in the first semester, junior year. A third important feature of this program is its organizational and conceptual interrelation with the Felician College Associate Degree in Nursing program.

The college location, in northern New Jersey, in the densely populated New York metropolitan area, has several implications for the program. These include a large pool of potential applicants, a program designed to build upon ADN and diploma education in general, and a rich source of qualified faculty. At the same time, the location is a competitive one. The burgeoning number of academic programs in the area that cater to registered nurses make the area a "buyers market" for the applicants.

Its first class of 60 students entered in September 1979 and its second class (63 students) in September 1980. About two-thirds of the students are part-time; all are required to complete the program in five academic years. This May (1981), it is anticipated that 16 students will graduate.

Felician College is a small liberal arts college, operated by the Felician Sisters. As such, the college offers much to the BSN Program, and at the same time, presents the gamut of problems common to professional academic programs housed in small, liberal arts colleges. Strengths include genuine commitment to the program, focus on teaching, and a personalized approach to students. Problems include isolation from clinical agencies and an insufficient understanding of and respect for professional nursing by other faculty. Another area of concern is that a small college may have unrealistic expectations of the program and its students. Program success requires that internal strengths and weaknesses be continuously addressed; the process of educating faculty colleagues and administration is an ongoing one.

Certain areas of concern exist throughout the entire process of program development: budget, faculty, students, student services, organizational arrangements, curriculum, evaluation and research. Internal and external influences have continuous impacts upon the program, but their position relative to each other waxes and wanes dependent on the phase of program development. These phases are: 1) planning, 2) implementation and 3) refinement and validation. The first goal was to gain program approval from the Department of Higher Education and the Board of Nursing. The second goal is to fully implement the program in a way that is positively perceived by all significant publics. The third goal is to achieve NLN accreditation.

The Felician program is currently in phase two. During these early stages of developing our program, we have enunciated a set of criteria in the form of questions which other programs may also find useful. Is the program that you are developing ...

...Logical? Does it make sense to you?

...Internally consistent? This is closely allied with logic and asks, "Is the program being and doing what it says it is being and doing?"

...Educationally sound? Is the program compatible with baccalaureate nursing education, with the state-of-the-art of educating RNs, with higher educational principles and practices, with NLN criteria? If some things are creative and innovative, are they educationally defensible?

...Marketable to potential students? Is there some reason why students should choose this program over another given geographic equality? (Market considerations are very important to private colleges.)

...Economically feasible? When will the program become economically self-sufficient, if ever?

...Compatible with the larger institution? Are the college's stated and unstated beliefs, values, traditions and practices compatible with those of the program?

Our essential purpose is to provide a quality baccalaureate program for registered nurses which is responsive to their particular learning needs while overcoming hurdles to educational mobility. Guiding a new program through the complex but challenging process of development requires scrupulous attention to a plan of action.

It should be realized that conflicts often exist between demands of various publics and between these differing goals. Consequently, the Program Director and faculty, but especially the Director, must be prepared to steer a steady course despite the obstacles of competing claims. It is essential to know the state-of-the-art of baccalaureate education for the RN and to determine which areas of the program are open to negotiation and which are not.

Although each program has its unique characteristics and areas of concern, common problems and resolutions can be identified and shared. Those of us committed to upgrading the profession by helping the RN to achieve a baccalaureate education in nursing can profit from this sharing process.

Reaching Beyond the Campus in Nebraska

Ann Van Hoff

Historically, Nebraska has been a state committed to diploma education for nurses. These have been well developed and productive programs, and they have long provided the state's supply of nurses whose primary area of employment has been in acute care settings. However, there has been continued awareness of the increasing need for upper division education in nursing.

During the late Sixties and the early Seventies, the University of Nebraska College of Nursing received numerous requests to expand its Baccalaureate program beyond the Omaha area. In 1975, a five-year curriculum study culminated in the implementation of the Articulated Associate and Baccalaureate Nursing Programs. This concept provided an excellent opportunity to consider developing the Baccalaureate segment of the program for delivery at sites away from the main campus.

The Baccalaureate Program was extended to Lincoln in 1976. During this same year, a proposal to expand the program to off-campus sites was submitted to the Kellogg Foundation. In 1977, the project was funded for four years. The Kellogg funding is designed on a de-escalating plan, so that in 1980 we are on approximately 60% grant monies and 40% state monies.

The initial program was designed to provide two areas of Nebraska, outside the immediate Omaha and Lincoln area, with a program by which registered nurses could obtain a baccalaureate in nursing in a minimum of four years. The areas selected as program sites were Scottsbluff, 450 miles west of Omaha, and the mid-state area of Grand Island, Kearney and Hastings, 150 miles west of Omaha. Each of the areas selected had one or more diploma programs as well as a state or community college.

Objectives

The objectives defined in the initial grant proposal remain relevant today.

1. To extend educational opportunities to registered nurses in outstate Nebraska by (a) Enabling these nurses to enroll in upper division science and nursing courses, and (b) Making it possible for these nurses to earn academic credit for these courses and to complete the University of Nebraska's requirements for Bachelor of Science Degree in Nursing.

2. To collaborate with the state and community colleges in an educational venture that will meet the expressed needs of registered nurses, increase student enrollments at these institutions and augment the supply of nurses prepared at the baccalaureate level in nursing.

3. To provide the rural areas of Nebraska with nurses who are prepared to function more effectively in hospitals and in community health services such as school nursing, long-term care, community health.

The Process of Implementation

From the beginning, it was recognized that such an undertaking would require close collaboration and cooperation with the state and community colleges. Therefore, during 1976, the Dean of the College of Nursing and the Assistant Vice President for Academic Affairs met with the administrative personnel of each of the colleges to discuss and later to finalize agreements with them. This process has continued so that we now have agreements with three state colleges, three community colleges and agreements in process with two additional community colleges.

These colleges assist nurses in completing prerequisites and provide an opportunity to obtain non-nursing required and elective courses with the state colleges providing as many upper division courses as possible. (See Appendix A.)

The final step in making this arrangement a reality was accomplished when the Board of Regents of the University of Nebraska waived the requirement of completing the last thirty (30) hours of course work on campus for this program.

Course content is the same as for the on-campus program. It is the mode of delivery that is different. Content is delivered by video and audiotape, by telephone conference and by on-site clinical practice and conferences. Although the program originated on the Medical Center campus, the faculty of the Lincoln campus has been involved for the past two years.

We have traditionally used the colleges as locations for course materials. However, where there are longer distances and sufficient numbers of students, we use some hospitals. Additionally, several Nebraska hospitals who are on the telephone conference network out of the Center for Continuing Education at the University of Nebraska Medical Center allow us to use the equipment. Videotape equipment placed in agencies and colleges can be used by their personnel and students.

Program Continuance and Expansion

In the past two years, another city 300 miles west of Omaha, North Platte, has been added to the mid-state area. We have also added a northeast area which includes a state and community college that are approximately thirty miles apart.

Currently, there are 64 students admitted to the College of Nursing and 85 in the process of completing prerequisites.

At this time, the program truly spans the state (see Appendix B). Numbers of students remain quite constant; however, they do not meet the original projections. No doubt nurses have found that obtaining a baccalaureate in nursing can be quite demanding, and will require some adjustments in their life style and priorities.

Two of the nurses have come on campus in Omaha to complete their last semester. Both have received their BSN. Two others have transferred to the Lincoln campus and four have completed their degree requirements off campus.

APPENDIX A

UNIVERSITY OF NEBRASKA MEDICAL CENTER
COLLEGE OF NURSING

ARTICULATED BACCALAUREATE PROGRAM

PREREQUISITES

The prospective student must be:
1. A registered nurse.
2. A graduate of an associate degree program or an accredited diploma program.*

COURSES:

English/Humanities	6 hrs.
Sociology (Intro)	3 hrs.
Psychology (Intro)	3 hrs.
Anatomy & Physiology	6 hrs.
Microbiology	3 hrs.
Chemistry	6 hrs.
Nutrition	2 hrs.

BACCALAUREATE LEVEL COURSES

REQUIRED NURSING COURSES:

Health Maintenance	6 hrs.
Health Restoration	5 hrs.
Quality Assurance in Nsg.	3 hrs.
Management in Nursing	4 hrs.
	18 hrs.

NURSING ELECTIVES	12 hrs.

REQUIRED NON-NURSING COURSES:

Biochemistry	3 hrs.	
Immunology	1 hr.	
Pathophysiology	3 hrs.	
Pharmacodynamics	2 hrs.	
Statistics	3 hrs.	
Social Science	3 hrs.	(Society/Culture/Life Style)
Social Science	3 hrs.	(Organization/Change Theory
	18 hrs.	

NON-NURSING ELECTIVES	12 hrs.	
TOTAL		60 hours

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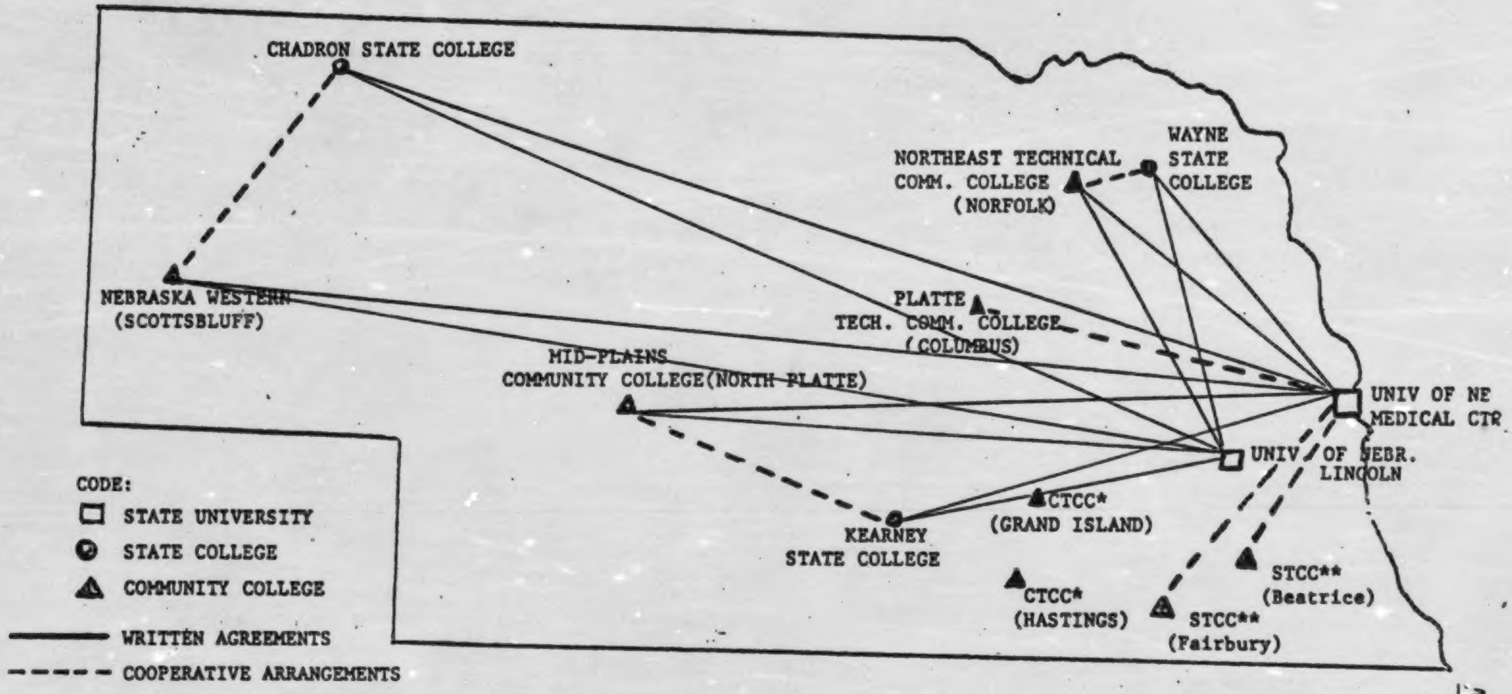
*Nursing content is validated, when necessary, by use of four of the New York External Degree (PEP) Proficiency Examination Program examinations.

APPENDIX B

UNIVERSITY OF NEBRASKA
COOPERATIVE PROGRAM
BACCALAUREATE NURSING EDUCATION


CHADRON STATE COLLEGE
NORTHEAST TECHNICAL COMM. COLLEGE (NORFOLK)
WAYNE STATE COLLEGE
NEBRASKA WESTERN (SCOTTSBLUFF)
PLATTE TECH. COMM. COLLEGE (COLUMBUS)
MID-PLAINS COMMUNITY COLLEGE(NORTH PLATTE)
UNIV OF NE MEDICAL CTR
UNIV. OF NEBR. LINCOLN
CTCC* (GRAND ISLAND)
KEARNEY STATE COLLEGE
CTCC* (HASTINGS)
STCC** (Beatrice)
STCC** (Fairbury)
CODE:
STATE UNIVERSITY
STATE COLLEGE
COMMUNITY COLLEGE
WRITTEN AGREEMENTS
COOPERATIVE ARRANGEMENTS

* Central Technical Community College is abbreviated to CTCC at Grand Island and Hastings.

** Southeast Technical Community College is abbreviated to STCC at Beatrice and Fairbury.

Combining Quality with Flexibility at Pace

Lynne Brodie Welch

Pace University has developed an upper division baccalaureate program for registered nurses that can be completed in two years of full-time or five years of part-time study. All courses, including both lecture and clinical laboratory components, are offered in the day and in the evening.

Interestingly, approximately 75% of our students take courses during the day and 90% of them attend on a part-time basis, taking about 6-10 credits/semester. Virtually all of the students work, most of them part time; but at least 25% are employed full time. The majority of our student population now tends to be AD nursing students who are continuing on immediately after their basic program, and practically all (97%) are women.

Curriculum Development

One key to successful program development is a philosophy which is consistent with baccalaureate nursing education and yet meets the needs of the learners, which we feel that we have achieved. Another key is sequencing of courses with an appropriate rationale for placement in the curriculum, which was accomplished although not without some difficulties.[1] Problems that I will discuss in more detail are in the areas of admission criteria, testing for admission, and clinical laboratory experiences.

All students in the baccalaureate nursing program must meet the general admissions requirements for Pace University. Our program articulates with Pace's lower division program which grants an Associate Degree in Applied Science in nursing. Thus, one of the admission requirements is the completion of the equivalent to the Pace AD program. These requirements include 35 units of General Education courses and 31 units of lower division nursing courses. That total, 66, is the maximum number of credits accepted for transfer. Students may take examinations such as NLN, CPEP and CLEP for admission/transfer credit in such courses as anatomy and physiology, communications, sociology, microbiology and electives.

In addition to course requirements, there are four other prerequisites for matriculation. 1) A GPA of 2.5 or its equivalent. 2) A grade of C or better in nursing, science and communications courses. 3) Successful completion of three theoretical examinations designed by the nursing faculty for which there is a charge of $25 per examination. These exams cover Adult, Maternal/Child, and Psychiatric/Mental Health nursing. 4) Successful completion of a clinical assessment, also developed at Pace, which makes use of simulation techniques. (See pages 132-136.) There is currently no charge for this examination.

Another problem is the decision about how much clinical laboratory experience there should be in the program. Our students earn 28 credits in nursing courses with a clinical component, as described below:

Course	Credits Earned	Lecture Hours	Lab Hours	Faculty:Student Ratio in Lab
Nursing Process in Health I Nursing Process in Health II	12	6	12	1:10 1:8
Nursing Process in Illness I Nursing Process in Illness II	10	4	12	1:10
Leadership and Change in Nursing Practice	6	2	8	1:10

A total of 130 credits are required for graduation. Since a maximum of 66 can be transferred in from the lower division, 64 credits must be taken in the baccalaureate program of which 36 are nursing courses, 12 are free electives and 16 are required courses. Altogether, 67 of the 130 credits required for graduation are in nursing. In addition to electives, other non-nursing courses included in the upper division program are Chemistry I & II, Group Relations and Interviewing Techniques, Organizational Behavior, and Statistics. Upper division courses in nursing, in addition to those with clinical components which were listed previously, include: Philosophy of Professional Nursing; Stressors in Health I and II; and Professionalism and Nursing Practice.

Faculty

At Pace University, the issue of recruitment and retention of adequately prepared nursing faculty is perhaps less acute than for nursing programs in other geographic areas. Over half of the full-time faculty either have doctorates or are pursuing doctoral studies in nursing. Of the nine adjunct faculty, two have doctorates in nursing and another is in a doctoral program. The reasons for this are two-fold. For the last few years, hiring practices have favored doctorally prepared individuals, and university policies support and facilitate doctoral study. The second reason is the proximity to New York City which has two doctoral programs in nursing.

Recruitment of faculty with master's degrees in clinical areas of Nursing of Children and Community Health Nursing continues to be a problem for us. In these specializations, the supply is small compared to the demand, at least in our section of the country.

Budget

A cost effective yet quality baccalaureate program in nursing presents a real challenge. Strong administrative support has been extremely important, since at present the upper division program is not cost effective. We do not qualify for capitation monies. Use of adjunct faculty for 35-40% of the teaching load helps to reduce the cost of the program. Large enrollments in lectures help to offset the very costly clinical laboratory experience. Nonetheless, beginning Fall of 1981, students will be assessed $100 per clinical nursing course to help defray the cost of laboratory instruction. This is similar to laboratory fees assessed in chemistry or microbiology.

Research

Nursing research is actively encouraged at Pace, but it is often difficult for nursing faculty to find the time and money to participate. University support has taken several forms: (1) a series of continuing education programs on the research process; (2) a Scholarly Research Committee to which faculty can apply for seed monies or reduced load to facilitate their research activities; and (3) computer consultants on-line time free of charge to the faculty member. On a departmental level, clerical, duplicating and mailing costs are borne by the School of Nursing whenever feasible. Despite University and School of Nursing support, however, the amount of nursing research being done is small.

Part-Time Enrollments

Pace University's baccalaureate nursing program for registered nurses has a unique flexible program designed to meet the needs of its students for full-time or part-time study, offering both day and evening classes. This very flexibility, however, creates a number of problems, as outlined below:

1. Keeping track of fairly large numbers of students who tend to drop in and out of the program;
2. Keeping up-to-date records regarding student completion of prerequisites for nursing courses;
3. Counseling and advising students who have complex program needs over an extended period of time; and
4. Working with problems encountered by students who are employed full-time, go to school part-time, and have family responsibilities.

Notes

[1] For us, chemistry was a particularly difficult problem since it is taken before all nursing courses in generic baccalaureate programs. Due to the focus of first semester senior year courses (Nur 250/251) on complex pathophysiological needs of clients, we required Chemistry I & II as prerequisites. A second semester senior year nursing course focuses on leadership, management and research skills, thus the prerequisites of courses in organizational theory (a management course) and statistics.

Panel Discussion III

ACCREDITATION OF SECOND STEP PROGRAMS

Moderator: Joyce A. Ellis, R.N., Ed.D.
Head and Professor
Department of Nursing
Evaluation Associate, NSSP
Purdue University--Calumet
Hammond, Indiana

Credible Nursing Education for RNs

Donna Arlton, Ed.D.
Chairperson and Professor
Department of Nursing and
Health Care Management
Metropolitan State College
Denver, Colorado

Accreditation as It Relates to Second Step Programs

Mary E. Duffy, R.N., Ph.D.
Director, Division of
Baccalaureate & Higher Degree Programs
National League for Nursing
New York, New York

Rigorous Peer Review: A Mandate of Professionalism

Irene S. Palmer, Ph.D.
Dean, Professor of Nursing
School of Nursing
University of San Diego
San Diego, California

Second Step Accreditation: Problems and Recommendations

Mary Searight, R.N., Ed.D.
Director, NSSP
Professor of Nursing
Sonoma State University
Rohnert Park, California

Issues in Accreditation

Jonathan R. Warren, Ph.D.
Senior Research Scientist
Educational Testing Service
Berkeley, California

A word about the panels . . .

Feedback from the National Second Step Project's 1980 research conference convinced us that one of the primary values for participants stemmed from the opportunity for meaningful dialogue focused upon central issues facing Second Step nursing education. Three panel discussions were scheduled to expand that opportunity in the 1981 conference.

The session reported here dealt with an extremely sensitive topic among Second Step educators--one that stimulates more whispered anxieties than public discussion: the issue of NLN accreditation. Space limitations prevent our inclusion of the discussion in its entirity. However, the introductory remarks of each invited panelist are presented on the following pages, and the leading questions around which the discussion revolved are presented below.

- Should criteria for the accreditation of Second Step baccalaureate programs be different from those developed for generic programs?

- Should the accrediting agency legitimize the need for these programs--characteristically designed for adult, experienced registered nurses--to incorporate more specialization and/or expanded-role experiences into their undergraduate curricula than programs planned for generic students?

- What effect does the accreditation process have on programs, on faculty and on students? Does it encourage and support excellence? Can it stifle potentially creative and innovative ideas? Are the results always positive?

- Of what practical purpose is accreditation? Are the results worth the time, the effort and the money expended? Is the process cost-effective? Is the cost/benefit ratio favorable?

Credible Nursing Education for RNs

Donna Arlton

There are several reasons for my interest and involvement in Second Step nursing education. First, as a woman, I feel acutely the need of women in our country for equal opportunity in education and in the world of work. Traditionally, both were designed for men, with women having fewer educational opportunities, consistently occupying the lowest ranks of work, and receiving the lowest salaries. Nursing education mobility programs provide a way for women to achieve personal and professional growth and autonomy as well as opportunity for an improved standard of living.

Second, my background in the health field makes me acutely aware of the needs of citizens in our country for improved health care delivery. Statistics show that approximately 80 percent of the nurses in the United States have less than baccalaureate preparation in nursing. At the same time, the demand for more highly sophisticated nursing knowledge and skills is increasing; more and more health care problems are being treated in community settings outside of the hospital, and a higher proportion of those treated within the hospital are acutely ill. This situation demands an increase in the number of nurses prepared at the baccalaureate level. It is unreasonable to believe that generic baccalaureate nursing programs will be able to produce the numbers of skilled practitioners needed now and in the future. It is eminently reasonable to tap that large reservoir of associate degree and diploma nurses, providing for them an opportunity to develop the nursing knowledge and skills needed for improved health care delivery to today's clients.

There are several avenues for baccalaureate education mobility for associate degree and diploma nurses. One avenue is through advanced placement in a generic baccalaureate program. Another is by way of a Second Step baccalaureate program for registered nurses. The latter alternative has been, and still is, controversial.

A number of questions have contributed to the controversy. "Can the RN student be properly professionally socialized in a Second Step nursing program?" "Can professional nursing education be built on a technical base?" "What kinds of nursing knowledge and skill should be taught in such a program?" "How does one validate previously learned nursing knowledge?" "How does one develop teaching strategies for the adult learner?" "Should the RN student have more opportunity for nursing specialization and expanded role experience than the generic nursing student?" Well, I have spent the better part of the past six years in pondering and working out with my faculty solutions acceptable to us in regard to these questions as we developed our Second Step nursing program at Metropolitan State College in Denver, Colorado.

My faculty and I believe that we have identified the baccalaureate level nursing knowledges and skills lacked by associate degree and diploma nurses, and that our RN students can synthesize this additional knowledge with their previous nursing knowledge, thereby graduating as competent baccalaureate level professional nurses. We have developed procedures to assess and validate prior nursing knowledge, and have worked energentically to develop teaching strategies for adult learners. We have struggled with the question of specialization at the baccalaureate level, and have devised methods to allow the RN student to investigate nursing areas of special interest. We have tested and studied RN students from every angle: at entry; in progress; and at exit from our program. We have identified their demographic characteristics, personality needs, intelligence range, values, ability to conceptualize, and preferred learning styles. Employers compare their performance quite favorably with that of graduates from other baccalaureate programs.

My interests and concerns are for credible nursing education for registered nurse students wherever it occurs. During my efforts in helping others around the country develop Second Step programs, I have observed some of the difficulties commonly encountered in preparing programs which can be accredited by the National League for Nursing. For example, many colleges and universities are attracted to developing programs for registered nurses because they perceive them as bringing in large numbers of students in a time of steadily declining student enrollments. Unfortunately, some administrators do not appreciate the cost of developing such programs. In some cases, the number of faculty is inadequate or part-time faculty are substituted for full-time faculty. Classroom and office space, program equipment and library resources may be in short supply.

Another difficulty I have observed is that faculty who are selected to develop a Second Step program sometimes lack experience, not only in baccalaureate nursing education but also in curriculum and course planning and development. Money for program development consultation and faculty development may not be available.

In some instances, program planning does not include sufficient articulation efforts with surrounding nursing programs at the associate, diploma and master's level. Lack of such planning may increase the difficulty students experience in meeting program entry requirements and in transferring from one program to another.

In summary, my interest in helping women to improve their status, my interest in and concern for improved health care delivery to clients and my concern for the development of credible nursing education programs for registered nurses are the reasons for my being on this panel today. I am happy for the opportunity that we have today to share with each other our problems, our solutions, our frustrations and our successes on accreditation of Second Step nursing education.

Accreditation as It Relates to Second Step Programs

Mary E. Duffy

As I thought about the topic of accreditation and why I am seated on this panel, two reasons came to mind. I am here because, by virtue of my present position, I am responsible for the administration of the NLN's accreditation program which relates directly to baccalaureate and higher degree programs in nursing. The second reason is that I firmly believe in the concept of educational mobility within nursing education, and within baccalaureate education in particular.

The brochure for this conference states that baccalaureate programs designed expressly for registered nurses may well constitute the major thrust in professional nursing education of the 1980's. There is a great deal of truth in this statement. The latest statistics show that in recent years a growing number of registered nurses have enrolled in programs offering the baccalaureate degree in nursing. According to John Vaughn (1980, p. 5), the number of generic programs which admit RNs rose from 279 in 1975 to 330 in 1979. During this same time period, the number of Second Step programs rose from 50 to 99. Programs admitting only RNs comprised 23% of the baccalaureate nursing programs in this country in 1979, that proportion having increased substantially during the preceding four years.

RN graduations from baccalaureate nursing programs increased 70% in five years, rising from 3,791 in 1974-75 to 6,480 in 1979-80 (Vaughn, 1980, p. 7). Of this number, 2,380 RNs graduated from Second Step programs.

Ten years ago, when the first Second Step programs were being developed and implemented, they were considered quite non-traditional. Today, however, hindsight tells us that these programs truly predicted the wave of the future as it relates to education. Second Step programs are very much a part of the mainstream of higher education in nursing and will continue as such through the next decade. Jako (1980, p. 43) makes an important point when she states that "post-licensure education for registered nurses has moved swiftly from disrepute to merely controversial and now into a position of wide acceptance. But this has been primarily due to the external currents in the society, in the profession and in higher education generally." She also states that Second Step programs must be able to achieve a more solid negotiating stance with regard to the significant audiences they must address, one of which is the professional organizations by whom these programs must be accredited and legitimized.

For many of us, accreditation conjures up a mixture of feelings. One the one hand, it can be viewed objectively as a voluntary process designed to determine the quality of the process of education through predetermined standards or criteria, a process which ensures accountability, quality and integrity of programs and degrees. On the other hand, when accreditation of our own specific programs faces us, we become very fearful and anxious, not only because of the tremendous amount of work involved, but also because of the emphasis on self-examination and self-evaluation which is at the heart of the process. No one wants to be evaluated by others, least of all by our peers, who, by virtue of their charge, must make a judgment as to whether our program measures up to these external criteria. And so the accreditation process brings us face-to-face not only with our strengths but also with our limitations. If the decision of our peers is favorable, then our fears and anxieties diminish--we begin to view the process more objectively and can see it as a very productive, growth-producing experience for all. If the decision is not favorable, then the process and those involved in that process, become the focus of all of our emotions, most of which are negative.

All baccalaureate programs are evaluated according to one set of criteria. Emphasis is not placed on the level or kind of student admitted to the nursing program, but rather on the assessment of the total educational quality of the program in relation to predetermined criteria developed and adopted by the membership of the Council of Baccalaureate and Higher Degree Programs. The most important ingredient in the evaluation process is the exit behaviors of the graduate. The Characteristics of Baccalaureate Education define the baccalaureate graduate as a generalist nursing practitioner who can function in a variety of settings. The baccalaureate program, regardless of the type of student, should provide a basis in the biological, social and behavioral sciences which underpin the nursing major.

Both the characteristics and the criteria were developed and adopted by the membership of the Council of Baccalaureate and Higher Degree Programs. They have been revised several times and are due for another revision in the next two years. The important point to remember with regard to these two documents is that they are the outgrowth of the beliefs of professional nursing educators as to what constitutes the product of baccalaureate education and what constitutes the standards by which baccalaureate programs in nursing are evaluated. These documents provide a uniform set of nationally defined standards, broad enough in scope and direction, to be applied to any type of baccalaureate nursing program (NLN, 1979; NLN, 1977).

Standards and criteria utilized to appraise professional nursing programs must be the same for all programs which offer the same degree or credential. Nursing educators have spent a great deal of time and energy over the years to obtain uniform preparation at the baccalaureate level and at the same time ensure that each program could develop its own unique character in keeping with its mission within a particular college or university. To have a different set of criteria for the appraisal of Second Step programs would result in pronounced differences among baccalaureate nursing programs, an unevenness in the academic quality of baccalaureate nursing education, and the loss of any minimal equivalence among baccalaureate degrees in nursing. This would result in the idea that a baccalaureate degree from one school might be considered more valuable in the job market than a degree from another school.

The nursing profession already has too many levels of practice with which to contend. This has been a constant source of friction and dissension for many years. Baccalaureate education has not had this problem because it has been united in its beliefs about what is produced and what type of education is needed to prepare the professional nurse.

Can we really document that the graduate produced in a Second Step program is more than, or different from, the graduate of a generic baccalaureate program? Do we really want this difference? Can the society afford and/or absorb still another intermediate level praotitioner?

No one will deny that the student population is changing so that the older, more experienced, part-time student is the norm rather than the exception. Does this change mean that we must change the entire meaning of the degree, or does it mean that we must adopt methods or modes of educational practices suited to the changing student population? Another factor to keep in mind in this regard is that there may be a peak in the next few years in the numbers of RNs seeking baccalaureate education. Right now, there is a very rapid growth rate of Second Step programs; but there was only a modest year-by-year increase in the number of RN enrollments for the 1975-79 period. In baccalaureate programs for registered nurses, the enrollment figures have shown a modest increase, rising from 32% of the total RN enrollments in 1975 to 38% in 1979. Even though the growth rate in RN graduations has been continuous for the past five years, it was especially high in 1974-75 and 1975-76, when it exceeded 25%. The graduation rate then waned in each succeeding year. In 1976-77, there was a 14% rise, following by a 13% rise in 1977-78, and only a 5% rise in 1978-79 (Vaughn, 1980, p. 5). Thus, there is a growing discrepancy between the relatively high enrollment rates and low graduation rates of RN students. This prolongation between entrance and graduation probably arises from many factors, some of which are: the increasing cost of education, the part-time character of the adult student, and the multiple personal and professional responsibilities which the RN student assumes. In addition, all professional education is costly, but Second Step education can prove to be very costly due to the fact that at the upper division level, a higher faculty-student ratio is needed in the clinical courses. And students matriculating in such programs can, and often do, take their lower division preparatory course work at other institutions. Thus the receiving institution does not always benefit from the revenues produced by student enrollment in these courses.

There is definitely a need for a variety of types of educational programs to prepare baccalaureate graduates. I am not at all sure that the number of Second Step programs that are being planned and implemented at the present time will all survive in the next decade. Nor am I sure that the numbers of RNs seeking admission to such programs will continue to increase as we had formerly predicted.

The period of the Eighties will see many drastic changes taking place in higher education. Economic retrenchment is the name of the game. Many of the more recently developed Second Step programs began not just because there was a need for educational programs for RNs, but also because many private, liberal arts colleges are struggling for survival; and RNs, during the past few years, have provided a very good target population to focus upon in order to fill enrollment quotas. The question remains: Will the RNs come in sufficient numbers to maintain these programs as viable educational units within these institutions?

Whether you agree or disagree with, like or dislike, the current accreditation process which you, who are members of the nursing education community, have adopted, accreditation of nursing programs is probably the strongest, most reliable, and least suspect credentialing system. It is the "most effective present mechanism for protecting students, society and established programs of proven integrity against degree mills and unscrupulous practices" (Ozimek, 1976, p. 6).

What is needed in the 1980's is not the abandonment of the accreditation process, but the refinement of the characteristics and the criteria so that they will continue to be flexible, uniform and universal in their application, thus allowing all types of baccalaureate nursing programs to be innovative and responsive to the changing career needs of students, and at the same time providing for continuous development and improvement in the quality of educational programs in nursing. In this way, the integrity of baccalaureate nursing education will be maintained not only within the profession, but also within the educational community and the public at large.

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Rigorous Peer Review: A Mandate of Professionalism

Irene S. Palmer

My interest in the accreditation process relates to professional nursing programs, which are identified as those leading to baccalaureate or post-baccalaureate degrees and not solely programs for RNs seeking the baccalaureate degree.

My concerns and interest stem from a long familiarity with local, state and national efforts to promote academic excellence and to fulfill the public's needs for professional nursing practice; with seeming perpetual ambivalence, confusion and ignorance among nurses about the characteristics of and education for the professions; with an internal complacency and inertia among too large a number of nurses; and with an anathematizing of the concept of excellence within nursing. Throughout the system of higher education, degrees have come to mean the acquisition of parameters of knowledge and proficiency. Logic would indicate that the baccalaureate degree in nursing, whether generic or post RN, ought to represent preparation for the same professional outcomes which have been developed by appropriately identified structures within the profession. A rational inference follows: the determination of the ways in which these professional products are prepared ought to be through the application of those standards and measuring devices used for all programs conferring the same degree.

Accreditation is a voluntary activity in which a group makes the decision to participate in order to meet standards established by their peers. The standards exceed those set down by regulatory or governmental bodies. These standards have been established to assure the various publics that the accredited status identifies an educational program as having achieved a measure of excellence beyond the average or minimum requirement.

Nursing has a long history of pursuing academic excellence in the face of obstacles presented by a wide range of persons, within as well as external to nursing, who seemed not to understand that the attainment of excellence in preparation for practice was correlative with a professional requisite, namely the protection of the public.

Abuses of the educational process, misrepresentation of educational outcomes, educational control external to the profession, and inadequacies in instructional personnel and facilities have all been enormous influences on the development of an accreditation system which strove to measure education for nursing.

Persons with prescience and vision as well as cognizance of prevailing systems of education for other occupations and professions struggled heroically to construct respectable and sound programs worthy of the name education. An educational standard applicable to all was a belief of nursing's earliest and greatest leaders.

The concept of the grading of nursing schools to inform the public as well as the profession of educational programs that were above average, and, by inference, to identify those which were not, had its origin at least three-quarters of a century ago. The consequences of this operation have been consistent efforts to improve the quality of education, to approximate the goals and ideals of academic preparation for professional entry and the adoption of instructional philosophy, psychology, technology and research into the system of nursing education. Innovation, inventiveness, originality and ingenuity followed from attempts to grade and later to accredit schools, and a healthy competitive atmosphere prevailed.

The maximal intellectual and professional development of students requires that all curricula be sufficiently flexible to encourage the learner's growth. But if a degree stands for the same object, then how can it provide for beginning preparation and specialization at the same time? I subscribe that it does not; that specialization occurs at the graduate level. Are we saying that the so called "expanded-role" function, which is taught in a wide variety of settings, academic and otherwise, is specialization at the baccalaureate level of preparation? I subscribe that it is not, in that expanded-role functions are those obligations, skills and expertise of all baccalaureate-prepared nursing professionals. If some students have more experiences and technical skills inherent in their backgrounds, then their ultimate outcomes may be more developed and mature; but the activity is the same.

That striving to meet the exceptional standards and a rigorous review process results in superiority or selectivity can be of little doubt.

What needs to be avoided are two ever present dangers: incrustation of academic models combined with a supercilious attitude toward those which sail against the wind, and the expectations that accreditation is a right due every institution which applies, the former danger held by the review structure, and the latter danger held by the applicant.

In short, I believe any review process, any self-evaluation leads to correction, reform and the pursuit of excellence. It is inherent in the obligations of all professionals. The welfare of the public demands it.

Second Step Accreditation: Problems and Recommendations

Mary Searight

My personal experience with the NLN accreditation process, which occurred when we prepared our Self-Evaluation Study and entertained our visitors seven years ago, produced mixed feelings. The anticipation of the event was terribly anxiety producing and a cause for uncertainty and fear and many sleepless nights. This resulted, I am sure, from a lack of knowledge about how the process worked and the dreadful consequences which would occur if initial accreditation was denied. Not only would the status of the nursing program suffer within the university and community, but ten senior students would be denied admission to graduate school.

The positive part of the accreditation process began with the arrival of our visitors in the Spring of 1974. They were friendly, warm, receptive people who did a tremendous job. They reorganized our carefully arranged schedule, made unscheduled classroom and clinical visits, poked around in our files, asked for information which we did not have, and as near as I could determine later, did what most visitors do. On the other hand, they worked tirelessly, evenings and nights, and wrote a most comprehensive report--a particularly difficult task in that they had not previously encountered a Second Step model nor had they experienced the task of sifting such a model through the accreditation criteria. For example, they requested the preparation and submission of supplemental data which they felt would be helpful to the reviewers, but which we had not previously included. Needless to say, their stock soared even higher, as did that of the Board of Review, when we received full accreditation for eight years.

Some of my colleagues have had similar happy experiences, but many have not. A survey of Second Step programs conducted by the NSSP in the Fall of 1978 showed that two-thirds of all Second Step programs which had sought initial accreditation prior to that date had been denied. Because I have never served on the NLN Board of Review nor have I served as a visitor, my information comes mainly from formal and informal consultation. Some of the programs seeking accreditation definitely acknowledged that they had problems and weaknesses; and while they were disappointed that they were unable to achieve accreditation, they accepted the report and tried again. Others felt they had a strong, quality program and could not understand why they were denied accreditation. How could this happen? Why would there be such a discrepancy between the reviewers' and the administrator and faculty's views of the program? Further, when the report of denial was issued, uncertainty continued because of a lack of clarity about the reasons given by the Board of Review.

Interestingly, some of these questions were answered for me in an unanticipated way. As a part of the data collection process related to my study of the leadership styles of administrators of Second Step programs which I reported yesterday, a final interview question was, "Is there anything else related to program development and the accreditation process which you would like to mention?" Nine out of ten administrators' responses related to accreditation and focused mainly on two points: 1) the criteria for accreditation are unclear and subject to a wide range of interpretations, and 2) there are no guidelines for the preparation of the Self-Evaluation Study. It is to these two points that I would like to address my remaining comments.

I must concur with the statements made by the respondents. In my estimation, in many instances, criteria are ambiguous, complex, nonspecific and extremely difficult to measure. If one is to participate in an evaluation process, one should understand the criteria and be clear about the action or behavior expected to meet that criteria. Presently, considerable doubt exists in the minds of many about appropriate outcomes. However, I am encouraged by the work being done by the Accreditation Committee toward this end, and I am especially interested in the recommendations related to the development of criteria which can be quantified and more easily understood.

The second point made by those administrators interviewed related to the lack of guidelines for the preparation of the Self-Evaluation Study. I think it is unlikely that a poor program would be accredited because of a super writing job had been done on the Self-Evaluation Study, but I think it is likely that some programs may have been denied accreditation because of a poor writing job. The reviewers make their decisions about a program based upon the Self-Evaluation Study and the visitors' report. During the review process, many programs need to be reviewed and time is limited. If the report does not contain the appropriate material, clearly stated and documented, readily comprehensible, then it stands to reason that a review committee could determine that the criteria had not been met. On the other hand, two or three and possibly more years of work could have been invested in the initiation of a quality program; but because of inexperience, the lack of writing ability among the faculty and/or faulty judgment about what to include, accreditation could be denied. My point is that I think every effort should be made to assist program administrators and faculty in preparing the very best report possible to represent the quality of the program.

When the criteria for accreditation are again revised, I anticipate that they will be more simply stated and more clearly understandable and measurable. I would then recommend the formation of a task force to develop a Guide to the Preparation of the Self-Evaluation Study. This should contain guidelines for the format and organization of the report. It should include definition of terms and examples of appropriate materials which could be submitted. Ideally, this document would be fairly straightforward. I believe that by providing more clarity to the criteria and structure to the process, candidates for accreditation, the visitors and the reviewers would all benefit.

Issues in Accreditation

Jonathan R. Warren

From 1977 to 1980 I conducted a study of the criteria and procedures used by what was then the U. S. Office of Education to evaluate accrediting agencies. This was a step or two removed from the evaluation of educational programs by accrediting agencies, but the processes are quite similar. Two major issues emerged in that study. One was the clear distinction in accrediting practice, both in published criteria and in the evaluative results, between the existence of appropriate organizational and educational structures and their effectiveness.

Virtually all accrediting agencies have sensible requirements involving the formal organization of the programs or institutions accredited, faculty qualifications, and broad curricular organization. Yet information typically is quite skimpy as to whether those formal requirements actually result in an effective administration, a productive faculty, or a curriculum that produces well-prepared graduates.

The criteria of the National League for Nursing are typical. And although I am going to be somewhat critical, I consider NLN to be an effective accrediting agency; the criticisms I have are equally applicable to virtually all accrediting agencies. NLN has six criteria related to faculty characteristics and responsibilities. Yet every one of those criteria could be met by a faculty that collectively was totally inept. I suspect that in such a case the visiting team would find some way to deny accreditation to that program, but it would be difficult. Program directors understandably expect negative evaluations to be related to the published criteria; and when all those criteria are met, denial of accreditation, no matter how well justified, is awkward. The possibility of that kind of situation occurring suggests problems with accreditation criteria, but again, those problems are pervasive in accrediting; they are not limited to nursing.

I'm aware of the difficulties that would be faced by accrediting agencies or any other body that proposed a critical, probing evaluation of faculty capabilities rather than faculty credentials. Most faculties would, with considerable justification, resist such an intrusion into their prerogatives. Faculty are generally capable, and the process of education is fluid enough that a limited set of evaluative observations based on some standard set of criteria might be more damaging than beneficial. Yet procedures can be established that would leave the evaluative process in the hands of the faculty themselves while giving the accrediting agency the task of verifying that the self-evaluative information produced by the faculty was authentic. Faculty groups and accrediting agencies working together should be able to establish a variety of self-evaluative procedures through which a program could provide evidence to the world outside that its faculty was performing effectively. We all have impressions of who the effective faculty members are, and why. The reasons vary widely and get mixed together in complex combinations, so that overall faculty quality cannot rest on a handful of characteristics. The problem to be solved, and I believe it is solvable, is to find ways to support systematically those commonly held impressions.

The second observation to come from the study of accrediting agencies is that they, including NLN, really have two quite distinct purposes. One is to discriminate unacceptable programs from those that are minimally acceptable. The other is to promote the continual improvement of acceptable programs. The same criteria and procedures cannot optimally serve both purposes. Requirements designed to separate the minimally qualified from the unqualified programs are unlikely to be of much use in helping qualified programs improve. And the reverse is also true. Observing, for example, whether a functioning faculty curriculum committee exists is a task entirely different from helping a program's faculty conduct a systematic review and evaluation of some aspect of the curriculum. Most accrediting criteria--those of NLN as well as virtually every other accrediting agency--are directed toward minimal qualifications. For example, most agencies require that faculty be involved in establishing and maintaining a suitable curriculum. Yet since most accrediting activities involve renewal rather than initial accreditation, the bulk of accreditation activities are directed to the improvement of already accredited programs. That's an imbalance that exacerbates the first problem I mentioned, and the two are in fact related. Providing support and assistance to effective programs for their further improvement requires more attention to their current effectiveness than to the simple existence of desirable organizational structures.

To this point, my remarks have been applicable to accrediting in general rather than to Second Step nursing programs in particular. For any comparatively new type of program, which is likely to be looked upon with some suspicion by the older, established programs, standards of quality are applied with unusual stringency. But that source of discomfort is balanced by the opportunity to try new, imaginative educational procedures without the inhibiting burden of tradition. Second Step nursing programs have an unusual opportunity to provide the expanding, perspective-broadening aspects expected in good baccalaureate programs to a population of mature, technically proficient, experienced professionals. That broadening of perspective does not imply that Second Step programs should consist largely of scattered offerings across all fields of the liberal arts, which is the level to which baccalaureate degree requirements often deteriorate. Instead, an unusually fertile opportunity exists to extend formal nursing education into its broadest possible context--into the connections between health care and the philosophy of science, historical determinism, community organization, cultural change, and any number of human dilemmas that are never resolved but only reconstrued. I would expect the process of early technical education followed by professional experience and then the integration of technical proficiency into an expanding treatment of professional application in a broad social and cultural context to produce superb professionals. The task for accreditation is to find ways to demonstrate to skeptical outsiders, or even to skeptics within the field, that that is indeed the case.

An issue has been raised by my panel colleagues that was also an important one in my recently completed study of accrediting. The dilemma found in the need to state criteria for accreditation that are broad and general enough to be applicable to a wide range of program types, and at the same time are specific enough to be useful, can never be wholly resolved. To stay with my earlier example, most accrediting agencies have a criterion something like, "The faculty must be competent." No one can take issue with the intent of that criterion, but it gives no help whatever to program directors faced with demonstrating that their faculty are in fact competent for the program's purposes, and who are uncertain as to what the agency means by faculty competence. Some agencies try to solve the problem by stating minimum requirements for percentages of faculty with Ph.D.'s and other readily observable qualities. But that just shifts the problem to the other horn of the dilemma by setting boundaries that are too detailed and rigid to accommodate diversity in programs' purposes, procedures, and particular circumstances.

A realistic solution is to state the basic criteria in broad terms that must be met and then provide a variety of ways each broad criterion can be elaborated to suit particular programs. Faculty effectiveness, for example, may be demonstrated through the statement of credentials and appropriate experience. It may also be demonstrated through documentation of student learning; through independent, expert evaluations of instructional procedures; through direct observations of faculty performance; through student judgments of quality of instruction; or through documentation of an effective faculty development program. Ideally, several such independent indicators of faculty effectiveness would be provided in the program's self-study, but enough alternative ways to documents the satisfaction of a general criterion would be suggested in the elaboration of that criterion that programs could choose which would be informative in their particular circumstances.

Accreditation of programs as well as licensing or certification of individuals are both matters of judgment. While they can never be reduced to mechanical determinations about the satisfaction of detailed requirements, a variety of defensible evidence in support of those judgments can be provided. Programs that depart from the familiar or traditional have a responsibility to develop evidence in support of judgments of their merit, and because they are different from the usual program, that evidence might also take unusual forms.

POSTER SESSION

Effects of Prior Nursing Experience on Performance in a Second Step Program--A Second Look

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Katherine L. Jako, Editor
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RESEARCHING SECOND STEP NURSING EDUCATION

JANUARY 12-13, 1981 CONFERENCE

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